PRINTED: 02/14/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JILTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE	
		155121	B. WING	G02/04/:	2011
	PROVIDER OR SUPPLIER	AYETTE	\$	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	TS .	F 00	00	
pp 1	Licensure Survey.	55121 75490		The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation on March 4, 2011. This facility also requests that an informal dispute resolution for deletion or reduction of F315.	
striet BX/BM	Census payor type: Medicare: 42 Medicaid: 85 Other: 21			RECEIVED	
	Total: 148 Sample: 24 Supplemental samp	ole: 7		FEB 2 8 2011	
i :	These deficiencies a in accordance with	also reflect state findings cited 410 IAC 16.2.		LONG TERM CARE DIVISION INDIANA STATE DEPARTMENT OF HEALTH	
SS=D	by Bev Faulkner, RI 483.10(b)(11) NOTI (INJURY/DECLINE/ A facility must imme	FY OF CHANGES ROOM, ETC) diately inform the resident;	F 15	It is the practice of this provider to immediately inform the resident,	
ABORATOR	DIRECTOR'S OF PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE,	TITLE (X	(6) DATE

eficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7TI211

Facility ID: 000051

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET ROSEWALK VILLAGE AT LAFAYETTE LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 157 Continued From page 1 F 157. consult with the resident's physician, consult with the resident's physician; and if and if known, notify the resident's known, notify the resident's legal representative legal representative or an interested or an interested family member when there is an family member when there is an accident involving the resident which results in injury and has the potential for requiring physician accident involving the resident which intervention; a significant change in the resident's results in injury and has the potential physical, mental, or psychosocial status (i.e., a for requiring physician intervention; a deterioration in health, mental, or psychosocial significant change in the resident's status in either life threatening conditions or clinical complications); a need to alter treatment physical, mental, or psychosocial significantly (i.e., a need to discontinue an status; a need to alter treatment existing form of treatment due to adverse significantly; or a decision to transfer consequences, or to commence a new form of or discharge the resident from the treatment); or a decision to transfer or discharge facility. the resident from the facility as specified in §483.12(a). What corrective action(s) will be The facility must also promptly notify the resident accomplished for those residents and, if known, the resident's legal representative found to have been affected by the or interested family member when there is a change in room or roommate assignment as deficient practice? specified in §483.15(e)(2); or a change in resident rights under Federal or State law or • Resident #88 physician was regulations as specified in paragraph (b)(1) of notified of deep tissue injury this section. and treatment was verified The facility must record and periodically update and placed on treatment sheet. the address and phone number of the resident's • Resident #11 blood sugars are legal representative or interested family member. monitored per physicians order with physician This REQUIREMENT is not met as evidenced notification per parameters.

Based on observation, record review, and

interview, the facility failed to ensure the physician

was notified related to a deep tissue injury and abnormal blood sugars. This deficient practice

effected 2 of 24 residents reviewed for physician

notification in a sample of 24. (Resident # 88 and

will be taken?

How will you identify other

affected by the same deficient

residents having the potential to be

practice and what corrective action

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES		PRINTED	: 02/14/2011	
CENTE	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM	APPROVED
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S	
		155121	B. WING			
NAME OF	PROVIDER OR SUPPLIER				02/0	4/2011
ROSEW	ALK VILLAGE AT LAF	FAYETTE	s	TREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	FION	· · · · · · · · · · · · · · · · · · ·
PREFIX TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	II D BE	(XS) COMPLETION DATE
F 157	Continued From pa	ge 2	F 15	7		<u>:</u>
	#11)		1 13.			
	Findings include: 1. During an observa.m., with LPN #11 (DoN) Resident #88 have a 0.5 cm (cent x less than 0.1 cm d the outer heel. Resident #88's record 3:25 p.m. Resident were not limited to, rextremity above the Documentation was physician had been resident.	During an observation on 1/25/11 at 10:40 m., with LPN #11 and the Director of Nursing oN) Resident #88's left foot was observed to ve a 0.5 cm (centimeter) x 0.9 cm (centimeter) ess than 0.1 cm deep tissue injury present to e outer heel. Sident #88's record was reviewed on 1/25/11 at 75 p.m. Resident #88's diagnoses included, but re not limited to, malnutrition and right remity above the knee amputation. Cumentation was lacking to indicate the visician had been made aware of the door.		 Residents who experien change of condition hat potential to be affected alleged deficient practi Nursing staff was re-edu on change of condition physician notification be Development Coordina /Designee by March 4, What measures will be put in place or what systemic change will make to ensure that the deficient practice does not the deficient practice does not the deficient practice. 	ve the by the ce. ucated and by Staff ator 2011.	
	An interview with LPI 1/26/11 at 10:30 a.m have been notified of Resident #88's heel i observation on 1/25/1 indicated she did not An interview with the a.m., indicated the MI of the deep tissue injudentified on 1/25/11. notification had not be by the LPN. 2. The clinical record eviewed on 2/4/11 at	the deep tissue injury on mmediately following the 11 at 10:40 a.m. The LPN notify the MD. DoN on 1/26/11 at 10:35 Dishould have been notified ary when the area was She confirmed the een made to the physician for Resident # 11 was 9:55 A.M. Diagnoses for but were not limited to		 Diabetic resident's blood sugars are monitored at tracked on the flow she daily by the licensed numbers. Nurse Managers review blood sugar flow sheet for any change of cond. The Nurse Manager on will be notified of acute resident changes. The Nurse Manager on will notify the Director Nursing Services and/o Executive Director of a change of conditions. 	d nd eet arse. the daily ition. Call e Call of r the	

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID lD (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 157 Continued From page 3 F 157 • Director of Nursing/designee is A current care plan for the resident, initially dated responsible to ensure 6/9/10, indicated the resident was at risk for compliance with facility adverse effects of hyperglycemia and procedure. hypoglycemia related to the use of glucose lowering medication and a diagnosis of diabetes mellitus. Interventions related to this concern

The physician's order summary for 2/11 indicated the resident had the following physician's orders:

included, but were not limited to, monitor blood

sugars as ordered and document abnormal

Check blood sugar twice daily

findings and notify the physician.

If blood sugar is less than 60 and the resident is responsive give 4 ounces of juice/milk, recheck in 15 minutes if still less than 60 call the physician

Review of the "Capillary Blood Glucose Monitoring Tool" for 1/11 indicated the resident had a blood sugar of 57 on 1/21/11 at 4:00 P.M. There was no documentation on the form to indicate the physician was notified of the residents low blood sugar level or that the resident's blood sugar was rechecked in 15 minutes.

There was no documentation in the clinical record to indicate the physician was notified of the resident's decreased blood sugar levels on 1/21/11.

During an interview with the Director of Nursing on 2/4/11 at 12:40 P.M., she indicated there was no documentation to indicate the physician was notified of the resident's decreased blood sugar on 1/21/11. She indicated the nursing staff should have notified the resident's physician at

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- A "Change of Condition" CQI tool will be utilized twice a week for 4 weeks and then weekly thereafter.
- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED	
/·		155121	B: WIN	IG		02/04	1/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAI	FAYETTE		190	ET ADDRESS, CITY, STATE, ZIP CODE 3 UNION STREET FAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1 '	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 157	that time. 3. A current facility by the Director of N A.M., titled "Reside indicated, "It is the changes in resident communicated to the family/responsible putinely, and effective Medical Change a. change in a resident marked change in personal to the for physician visit prevaluation. The licentify the physician action//intervention medical record as some decommunicated to the promptly. Routine of physician and mental aboratory and x-ray threatening g. Tor the resident will documentation in the same and the sam	policy, revised 3/10, provided lursing on 1/26/11 at 11:30 nt Change of Condition" e policy of this facility that all tondition will be ne physician and party, and that appropriate, e intervention occurs Acute Any sudden or serious at's condition manifested by a physical or mental behavior will to the physician with a request comptly and/or acute care ensed nurse in charge will d. All nursing will be documented in the noon as possible after resident set Routine Medical otoms and unusual signs will be medical record and e attending physician changes are a minor change in all behavior, abnormal results that are not life the licensed nurse responsible continue assessment and e medical record every shift		57			
F 164 SS=D	3.1-5(a)(2) 483.10(e), 483.75(l) PRIVACY/CONFIDE The resident has the	ondition has stabilized" (4) PERSONAL ENTIALITY OF RECORDS e right to personal privacy and or her personal and clinical	F 1	64 I I I I	F164 Personal Privacy/confidentiality of record is the practice of this provider provide each resident with the reservoid privacy and confidential finis or her personal and clinic ecords.	r to ight to ality	

DEPAF	RTMENT OF HEALTH	AND HUMAN SERVICES				PRINTE	D: 02/14/2011
		& MEDICAID SERVICES				FORM	APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		TPLE CONSTRUCTION	(X3) DATE S	
		155121	B. WIN	G_		004	0.4/0.044
AME OF	PROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	02/0	04/2011
ROSEW	ALK VILLAGE AT LAF	AYETTE		1	1903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD RE	(X5) COMPLETION DATE
F 164	Continued From page	ge 5 cludes accommodations,	F 10	64	What corrective action(s) wi	Il be	:
	medical treatment	written and telephone			accomplished for those resid	ents	
	communications, pe	rsonal care, visits, and		:	found to have been affected l	by the	
	i meetings of familγ a	nd resident groups, but this			deficient practice?	-, -,-	į
•	does not require the room for each reside	facility to provide a private		į	•		
	Froom for each reside	ent.			• Residents #63, #88 & #1	115	
	Except as provided i	n paragraph (e)(3) of this		1	receive resident care as		-
	section, the resident	may approve or refuse the			provided to ensure pers		i
	release of personal and clinical records to any individual outside the facility.				privacy.		
	and clinical records or resident is transferre institution; or record in the facility must kee.	o refuse release of personal does not apply when the d to another health care release is required by law.			How will you identify other residents having the potential affected by the same deficient practice and what corrective will be taken?	t	
:	contained in the resid	dent's records, regardless of		-			į
	release is required by	nethods, except when			• Residents who reside in		
:	healthcare institution;	law; third party payment			facility have the potenti	al to	
	contract; or the reside	ent.		1	be affected by the allege	ed	
-				:	deficient practice.	i	
· i	by: Based on observation	is not met as evidenced			 Staff was re-educated on resident rights by Staff Development 		
ı	review, the facility faile	ed to ensure privacy was		:	Coordinator/Designee b	y	
1	maintained during trea	atments provided by facility			March 4, 2011.		
: 1	esidents reviewed for	ractice effected 1 of 24 r privacy in a sample of 24;		:			
a	and 2 of 2 residents in	a supplemental sample of			What measures will be put in		
7	7 (Residents #115, #	63, and 88).		· I	olace or what systemic change	es you	
	indings include:			į	vill make to ensure that the leficient practice does not rec	•	
4	During black to				A		
i u	nedication administra	se checks and insulin tion observations on					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		155121	B. WING		02/0	4/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LA	FAYETTE	STREET ADDRESS, CITY, STATE, ZIP CO 1903 UNION STREET LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Director of Nursing observed: 1a. During a blood subsequent insulin 4:10 p.m., LPN#15 close the door to R the privacy curtain. to lift her shirt. The the resident's abdo daughter was in the administration. The the hallway going p the treatments. 1b. During a blood subsequent insulin 4:22 p.m., LPN #15 close the door to Reprivacy curtain. The her shirt. The insulinesident's abdomen resident's in the hall room during the treatments. During an interview following this observational observations and interview following the observations and interview following the observations in the sident's curtains in the sidents curtain the sidents	glucose check and administration on 1/24/11 at did not make any attempt to esident # 115's room or pull. The LPN asked the resident insulin was administered in men. Resident # 115's a room at the time of the insulin ere were staff and residents in ast the resident's room during glucose check and administration on 1/24/11 at did not make any attempt to esident # 63's room or pull the a LPN asked the resident to lift in was administered in the there were staff and livay going past the residents	F 16	 The Interdisciplinar will round daily to privacy issues. The licensed nurse wo observe for privacy during rounds on the assigned shift. The Executive Direct Social Service Work attend Resident Conthe permission of the President, monthly months to identify address privacy issues. Director of Nursing/responsible to ensure compliance with fact procedure. How the corrective action monitored to ensure the difference will not recur, i.e. quality assurance program put into place? A "QIS resident interest CQI tool will be contwice a week for 4 with the weekly thereaft. The CQI committee weekly thereaft. The CQI committee weekly the data gath. 	will vissues neir etor or ker will uncil, with ne Council for three and nes. designee is re cility (s) will be deficient ., what n will be rview" mpleted weeks and ter. will	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
$(\ddot{\cdot},\cdot)$		155121	B. WIN	IG_		02/04/2011	
	ROVIDER OR SUPPLIER	FAYETTE		1	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	a.m., with LPN # 11 (DoN) of a dressing foot, the LPN failed privacy curtain in the removed the old dreasessed the resider and staff observed dressing change. During an interview following the observed should have shut the Curtain closed. 3. A current facility by the Executive Directive United "Resident Right members recognize times and residents to enable personal of delivery of care The personal privacy and personal and clinical includes accommod treatment personal its residents in a mathat maintains or en	vation on 1/25/11 at 10:40 and the Director of Nursing I change on Resident #88's to close the door or pull the e resident's room. The LPN essing, cleansed, and ent's foot with the door to the privacy curtain pulled. The as not closed until the DoN left froom with supplies needed to not's foot. There were residents in the hallway during the with LPN #11 immediately ration, she indicated she door. with the DoN immediately ration, she indicated the LPN e door or pulled the privacy policy, revised 1/06, provided rector on 1/25/11 at 8:50 A.M., nts" indicated, "All staff the rights of residents at all assume their responsibilities dignity, well being, and proper he resident has the right to d confidentiality of his or her I records. Personal privacy	F 1	64	<u> </u>	eveloped. Cacility may ducation up ination.	
				į			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		155121	B. WI			02/0	A/2044
	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD 1903 UNION STREET LAFAYETTE, IN 47904			4/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 241	INDIVIDUALITY The facility must proper manner and in an element of the enhances each result recognition of his REQUIREMENT by: Based on observation of the enhances each result recognition of his REQUIREMENT by: Based on observation of the enhances of the facility dignity was maintain clothing protectors of excessive facial haid prolonged exposure perineal care. This 24 residents review	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality. It is not met as evidenced on, record review, and y failed to ensure resident's ned related to the use of to wipe resident's mouths, it for female residents, and e of the buttocks during deficient practice effected 7 of ed for dignity in a sample of		64	F241 Dignity and Respect of individuality It is the practice of this providuality assure that the facility promofor residents in a manner and environment that maintains of enhances each resident's dignerate respect in full recognition of her individuality. What corrective action(s) was accomplished for those resident to have been affected deficient practice?	der to tes care in an r nity and his or vill be dents by the	
	and #134) Findings include: 1. During the meal second floor on 1/24 following was observable. 1a. Resident #41 w QMA #17 was observable to 2 times to There was a napkin resident's plate of for 1b. Resident #148 v QMA #16 was obserprotector 4 times to 1	as being fed by QMA #17. Eved using the clothing wipe the resident's mouth. on the table next to the			 Residents #27, #41, #7 #134, #135 and #148 resident care as provious ensure dignity during activities of daily living administration of trea. Staff were re-educated Development Coording designee on the imposusing napkins and/or washcloths for pre-/pocleansing at meals; cludoors and curtains princompleting care on reand covering resident. 	receive ded to ng and tments. by Staff nator/ rtance of ost- osing or to sidents	

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 241 Continued From page 10 F 241 • The Executive Director or in the 2 nd floor dining room. The resident was Social Service Worker will noted to have excessive facial hair on her chin. attend Resident Council, with During an interview with the DoN on 1/27/11 at the permission of the Council 10:50 A.M., she indicated every female in the President, monthly for three building with facial hair should be taken care of. months to identify and She indicated staff should honor the resident's address dignity issues. preference for the method of hair removal. She indicated a resident's facial hair should be taken • Director of Nursing/designee is care of everyday of the week. responsible to ensure compliance with facility 3. During an observation on 01/24/2011 at 2:00 procedure. p.m., the bare buttocks of Resident # 135 was Each dining area will have visible by persons passing the open doorway of the resident's room. A staff person was in the washcloths available for pre hallway at the time of the observation. and/or post cleansing for meals. During an interview on 01/24/2011 at 2:00 p.m., CNA (Certified Nursing Assistant) # 4 indicated the resident's door was not closed and the privacy How the corrective action(s) will be curtain was not pulled since he was only in the monitored to ensure the deficient

room.

room to pick up a pillow from the floor. He

indicated he should have covered the resident's

4. During an observation on 01/25/2011 at 8:50

a.m., LPN # 1 completed a dressing change to

dressing change was observed by RN #3. Upon

completion of the wound care, LPN # 1 gathered

removed them from the bedside before pulling up

During an interview with LPN # 1 and RN # 3 on

resident's clothing should have been pulled up

01/25/2011 at 9:15 a.m., each nurse indicated the

the soiled dressing supplies and linens and

the resident's undergarment and slacks.

Resident # 134's wound on her coccyx (commonly referred to as the tailbone). The

exposed buttocks immediately when entering the

practice will not recur, i.e., what

put into place?

thereafter.

quality assurance program will be

• A "Dignity" CQI tool will be

weeks and then weekly

Noncompliance with facility

result in employee re-

policy and procedure may

The CQI committee will

completed twice a week for 4

review the data gathered and

if threshold is not achieved an

action plan may be developed.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2011 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION IDENTIFICATION NUMB		IDENTIFICATION NUMBER:	A. BUILD	DING	(X3) DATE SURVEY COMPLETED	
; 		155121	B. WING	i	02/04/2011	
ROSEW	PROVIDER OR SUPPLIER VALK VILLAGE AT LAF		S	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904	V21V4(2V11	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
	5. A current facility by the Executive Dir titled "Resident Righmembers recognize times and residents to enable personal deliver of careA faresidents in a manner.	policy, revised 1/06, provided rector on 1/25/11 at 8:50 A.M., hts" indicated, "All staff the rights of resident at all assume their responsibilities dignity, well being, and proper acility must care for its per and in an environment that ces each resident's dignity and	F 24		ıding	
F 252 3S=B	SAFE/CLEAN/COMF ENVIRONMENT The facility must provomfortable and hom the resident to use his to the extent possible	nelike environment, allowing is or her personal belongings	F 252	F252 Safe/Clean/Comfortable/Horenvironment It is the practice of this facility provide a safe, clean, comforta and homelike environment, all the resident to use his or her pobelongings to the extent possible	y to able lowing ersonal	
t E r e s a d re a m	by: Based on observation review, the facility fails environment was mai sanitary manner relate and a soiled chair in the deficient practice had resident's who ate in the and 27 of 27 residents.	n, interview, and record led to ensure the resident's intained in a clean and ted to a stove top with debris the dining room. This If the potential to affect all the second floor dining room		What corrective action(s) will accomplished for those reside found to have been affected a deficient practice? • No residents identified a leged deficient practice. How will you identify other residents having the potentia	ents by the by the ce.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/14/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 252 Continued From page 12 F 252 affected by the same deficient Findings include: practice and what corrective action will be taken? 1. During observation of the lunch meal on 1/24/11 beginning at 12:39 P.M., the following was observed: Residents who reside in the facility have the potential to A resident was transferred from a stationary be effected by the alleged dining chair to her wheelchair at 12:55 P.M. At deficient practice. that time, it was noted that the resident's pants were soiled with urine, and the dining chair was Housekeeping staff will be resoiled with urine. At that time, staff did not educated by the remove the chair from the table and the dining Housekeeping Supervisor/ room area. At the time of the observation, other designee on cleaning residents were seated at the table near the soiled chair. At 1:10 P.M., the Director of Nursing was procedure of soiled restaurant informed by the surveyor that the chair in the chairs and appliances by dining room was soiled. At that time, the Director March 4, 2011. of Nursing confirmed the chair was soiled and • Activities staff will be reshe removed the chair. She indicated the nursing staff should have pulled the chair out for the educated by the housekeeper to clean. She further indicated she Housekeeping Supervisor/ would ensure the chair was cleaned. designee on cleaning of appliances by March 4, 2011. A current facility policy related to the cleaning of the facility dining rooms, dated 10/02, provided by the Executive Director on 1/25/11 at 8:50 A.M., What measures will be put into titled "Restaurant Cleaning" indicated, "...The place or what systemic changes you Restaurant must always be clean, pleasant and will make to ensure that the aesthetically attractive. ... Restaurant chairs

was observed:

necessary...."

should be free from stains or food

remnants....Assess chairs, seats and arms, for food bits and stickiness. Wipe with damp rag, if

Supervisor, on 1/26/11 at 1:25 P.M., the following

2. During the environmental tour, with the Maintenance Supervisor and the Housekeeping

deficient practice does not recur?

After meals restaurant chairs

• Nursing and Activities staff

will be cleaned per procedure.

was re-educated on infection

control, including removing

restaurant chairs if soiled by the Staff Development

- Coordinator/designee by March 4, 2011.
- Nurse Managers will round daily to observe for a clean environment.
- Housekeeping Supervisor is responsible to ensure compliance with procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- Infection Control Unit Environmental Rounds tool will be utilized twice a week for one month and weekly times 3 months.
- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

If continuation sheet 13A of 84

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
c			A. BUI	LDIN	G		
		155121	B. WIN	NG _		02/04/2011	
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	FAYETTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904			
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F 252	Continued From pa	ge 13	F 2	252			
	care unit, the stove debris under the bu burners, there was a At the time of the ot nursing aide indicate recently, and she was been used for an ac An interview with the	e Housekeeping Supervisoring the observation indicated					
3S=E	a comprehensive, as reproducible assess functional capacity. A facility must make assessment of a res specified by the Statinclude at least the foldentification and der Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior prescribed assessment of prescription and derived as the foldentification and derived patterns; Communication; Vision; Mood and behavior prescriptions are prescriptions.	aduct initially and periodically ccurate, standardized ment of each resident's a comprehensive ident's needs, using the RAI e. The assessment must ollowing: mographic information; patterns; eing; and structural problems;	F 2	72	F272 Comprehensive Asset It is the practice of this provassess residents initially and periodically with a comprehaccurate, standardized reproassessment of each resident functional capacity. What corrective action(s) accomplished for those restound to have been affected deficient practice? • Resident #26, #96, #1 and #134 have comprehensive, accurassessments that refleresidents' current standard control of the providence of the practice of	rider to l densive, ducible s will be didents d by the 16, #125	

		C INCOTOR OF LAMBER				_UIVID INU.	U930-U39 I
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
: :		155121	B. WI	٧G		02/0	4/2011
	PROVIDER OR SUPPLIER 'ALK VILLAGE AT LAF	FAYETTE	1	19	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904	Van V	7/401:
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
And the second s	the additional assess resident assessment Documentation of purpose. This REQUIREMENT by: Based on record revious observation, the facinassessments were a updated related to use tract infections requisite (peripherally inserted removal, dialysis account and bladder, pressure AIMS assessments. effected 5 of 24 residence of 24 resider #116, #125, and #13	and procedures; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ; ;	F2	272	How will you identify other residents having the potents affected by the same deficie practice and what corrective will be taken? • Residents who reside it facility have the potent be affected by the alled deficient practice. • Licensed nurses were reducated on accurate assessments with resimple who utilize PIC lines, antibiotic usage, dialy by the Staff Developm Coordinator/designee March 4, 2011. What measures will be put place or what systemic charwill make to ensure that the	ial to be ent ye action in the intial to eged re- dents ysis sites, ment by into nges you e	
	Findings include:				deficient practice does not i	recur?	
	1/28/11 at 10:00 a.m #26 included, but wa hypothyroidism, recu infection), asthma, G reflux disease), dysp and a history of CHF The nurses notes ind	record was reviewed on n. Diagnoses for Resident as note limited to, anxiety, arrent UTI (urinary tract BERD (gastroesophageal bhagia (difficulty swallowing), (congestive heart failure). dicated the following: 1), Res (resident) c/o sore			 Residents who utilize antibiotics are put on hour report sheet as we the hot charting list. Physician orders and refor antibiotic usage we reviewed each morning (Monday thought Friedthe IDT Team, to enserted.) 	vell as on easons vill be ng day) by	

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 272 Continued From page 15 F 272 correct charting is being throat, cough, has nasal congestion lungs clear completed. Nurse Manager on notified MD await reply...." Documentation was call will review these on lacking related to vitals having been obtained. Saturday and Sunday. • Residents on dialysis and / or "...12/23/10 4:45 pm, N.O. (new order) Z-pak (antibiotic) po (orally) ii (two) initial dose, then i those with PIC lines will have (one) tab (tablet) x 4 days/URI (upper respiratory assessments flow sheet that is infection)...." Documentation was lacking to completed by licensed nurse. indicate a respiratory assessment and vitals had • Director of Nursing/designee is been completed. responsible to ensure "...12/24/10 12 am, Res resting, quietly in bed. T compliance with facility 97.0. 0 (no) c/o sore throat. 0 SOB(shortness of procedure. breath), cough noted at this time. 0 c/o pain/discomfort..." How the corrective action(s) will be Documentation was lacking to indicate any monitored to ensure the deficient assessment related to respiratory status or the practice will not recur, i.e., what use of antibiotic had been documented in the quality assurance program will be nurses notes from 12/24/10 at 12:00 a.m., put into place? through 12/25/10 at 9:45 a.m. "12/25/10 9:45 am...T (temperature) 98.6, p • A "Interim Care Plan / Hot (pulse) 68, r (respirations) 18, b/p (blood Charting Assessment" CQI pressure)111/68, SpO2 (oxygen saturation) 96% tool will be utilized twice a on room air. ATB (antibiotic) continues S (without) s/s (signs/symptoms) adverse effects...." week for 1 month then weekly Documentation was lacking to indicate what the times 2 months then quarterly lungs sounded like, if there was any cough or thereafter. sore throat. • The CQI committee will Documentation was lacking in the nurses' notes review the data gathered and related to a respiratory assessment having been

completed from 12/25/10 at 9:45 a.m., through

antibiotic to treat the upper respiratory infection.

During an interview with LPN #10 on 12/31/11 at

8:25 a.m., she indicated assessments should be

12/27/10 when the resident completed the

if threshold is not achieved an

action plan may be developed.

employee re-education and/or

• Noncompliance with facility

procedure may result in

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONSTRUCTION . DING	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		155121	B. WING	3	02/	04/2011	
	PROVIDER OR SUPPLIER		Ş	STREET ADDRESS, CITY, STATE, ZIP CO 1903 UNION STREET LAFAYETTE, IN 47904		0 11-0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	indicated the assess temperature, lung so breath. She indicate include any docume respiratory status of the assessments in lacking information a every shift. During an interview was 35 a.m., she indicated the as information related to vitals, sputum productions appropriately.	sted on every shift. She issment should include sounds, cough, shortness of ted the assessment should entation related to the fighther than the resident. She indicated the resident's chart were and had not been completed with LPN#6 on 12/31/11 at ated respiratory assessments all have been done every shift. It is sessment should include to auscultation of the lungs, action, cough, shortness of ed the assessments were not	F 27	disciplinary action including terminate Compliance date: March	tion.		
	on 12/31/11 at 8:40 a should have been as respiratory status ever assessments should temperature, cough, oxygen, and pain. Stoncerns with the lact nursing staff. 1b. A physician's order. "straight cath (urinational C+S (urinary catheter sensitivity) 12/28/10 the physician's orders increased (arrow up) confusioninterventional UA/C+S"	der, dated 12/27/10, indicated ary catheterization) for UA/erization/cultures and" A care plan attached to is indicated "problem agitation, anxiety + ionsstr (straight) cath/					
] -	The nurses' notes ind	Jicated the following:				:	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
um for a			A BU	LDIN	G		
(155121	B. WI	VG		02/04/2011	
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F 272	Continued From page 17		F	272			
	Awaiting lab pick up pain or discomfort lacking related to flu assessment had be was lacking to indic experiencing agitati	m., UA/C+S obtained. c0 (no) c/o (complaints of)" Documentation was uid consumption or urinary een completed. Documentation ate whether the resident was on, anxiety, or confusion.					
	from 12/28/10 throu related to fluid cons assessment having Documentation was	gh 12/30/10 at 2:45 p.m., umption or urinary					
	M.D. Awaiting C+S when available" indicate fluid consultation having been completed lacking to indicate wexperiencing agitation.	m., UA results returned from + colony count. Will fax MD Documentation was lacking to mption or urinary assessment eted. Documentation was whether the resident was on, anxiety, or confusion.					
:	signs) 128/74, 60, 1 was lacking to indicaprescribed antibiotic this time. Documen fluid consumption or been completed. Do	8 for UTI continues. VSS (vital 8, 98.2" Documentation ate the physician had as to treat the resident's UTI at station was lacking related to a urinary assessment having ocumentation was lacking to a resident was experiencing confusion.					
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	time Res had U/A 12/28/10. MD notific	is confused most of the + lab work done the ed + said not to do anything + C+S + colony count"					;

	T OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED	
£ .		155121	B. WING		02/	04/2011
	PROVIDER OR SUPPLIER	FAYETTE	190	ET ADDRESS, CITY, STATE, ZIP CO D3 UNION STREET LFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION . DATE
	consumption was be assessment had be assessment had be Documentation was related to fluid statuthaving been complethrough 1/4/11 at 9: A physician's order, "Septra DS (antib (two times per day) The nurses' notes in "1/4/11 9a (a.m.), for UTI. T (temperal (adverse reactions) lacking related to fluid assessment having Documentation was the resident was exported to the resident was exported to the resident was exported to the resident was exported. Documentation was consumption or a unbeen completed.	s lacking to indicate fluid being addressed or a urinary sen completed. Is lacking in the nurses' notes as or a urinary assessment eted from 1/2/11 at 11:00 a.m., 100 a.m., 100 a.m. Indicated 1/3/11, indicated iotic) i (one) po (orally) BID is (times) 5 days for UTI" Indicated the following: Ind	F 272			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		AULTIP ILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
·		155121	B. WI	NG		02/0	04/2011	
	PROVIDER OR SUPPLIER	·		19	EET ADDRESS, CITY, STATE, ZIP CO 03 UNION STREET AFAYETTE, IN 47904		772011	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
	"1/5/11 8:30 pm Temp 98.20 c/o Documentation was consumption or a been completed, indicate whether the agitation, anxiety, "1/6/11 2 am Results. T-98.0. 0 AVF discomfort" Docto fluid consumption having been complecking to indicate experiencing agitation. Documentation was or a urinary assess from 1/6/11 at 2:00 a.m. "1/7/11 11 am Conoted. T 97.4 0 c/o Documentation was consumption or a urindicate whether the agitation, anxiety, or agitation, anxiety, or agitation or a urindicate whether the agitation, anxiety, or agitation or a urindicate whether the agitation, anxiety, or agitation or a urindicate whether the agitation, anxiety, or agitation or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety, or a second consumption or a urindicate whether the agitation, anxiety.	Res continues on ATB/UTI. pain or discomfort" as lacking related to fluid urinary assessment having Documentation was lacking to ne resident was experiencing or confusion. s continues on ATB therapy for a noted.) c/o pain or umentation was lacking related on or a urinary assessment leted. Documentation was whether the resident was tion, anxiety, or confusion. s lacking related to fluid status ment having been completed a.m., until 1/7/11 at 11: 00 ontinues on ATB-UTI. 0 AVR pain or discomfort" s lacking related to fluid urinary assessment having ocumentation was lacking to the resident was experiencing	F	272				
	8:25 a.m., she indic resident with a UTI of urine, frequency urination, pain with resident, and fluids ndicated all this info documented on eve	cated assessments for a included urinary output, color of urine, urgency with urination, temperature of the should be encouraged. She						

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
G.		155121	B. WI	1G		02/0	04/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAI	AYETTE		19	EET ADDRESS, CITY, STATE, ZIP COE 03 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 272	Resident #26. During an interview 8:35 a.m., she indicresident with a UTI output, color of urinurine, dysuria, pain should be encouraginformation should She indicated docu assessments and owere lacking for ReDuring an interview 8:40 a.m., she indicresident with a UTI documentation of burine, color of urine response to antibior acceptance of fluids were not document resident every shift seeing documentatifluids. She indicate assessment and do UTI for Resident #2. The clinical recoreviewed on 1/25/11. A physician's order 10/2/10, indicated the peripherally inserted removed due to nor on the bottom of the the nursing staff were	with LPN #6 on 12/31/11 at cated assessments for a included vital signs, urinary e, frequency of urine, odor of with urination, and fluids ged. She indicated all this be documented on every shift. mentation of urinary locumentation related to fluids sident #26. with the DoN on 12/31/11 at cated assessments for a included every shift urning upon urination, odor of vitals of the resident, tics, pain upon urination, and as The DoN indicated the staffing assessments of the She indicated she was not ion of acceptance of increased dishe had concerns with stafficumentation related to the 26. Indicated the eresident # 96 was 1 at 10:15 A.M. for the resident was to have a discentral catheter (PICC) increase. The care plan update en physician's order, indicated are to assess the PICC site, of the catheter, and ensure	F	272			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ER/CLIA (X2) MULTIPLE CONSTRUCTION JMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED		
	-	155121	B. WI	NG		02/	04/2011
	PROVIDER OR SUPPLIER	AYETTE		19	EET ADDRESS, CITY, STATE, ZIP COE 03 UNION STREET AFAYETTE, IN 47904		54,2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	A nursing note, date indicated, "Notified resident's PICC line. There was no docur to indicate the reside discontinued or an at the time of the remode on 2/4/11 at 9:45 A.I. no documentation of the removal of the Piccontent of the removal of the Piccontent of the nurse who removed did not document an at that time. 3. The clinical recontent included history of renal failure. A nursing note, dated indicated, " res (restomorrow" A nursing note, dated indicated, " Res ret IJ (internal jugular) pechest" Review of the physici indicated the resident the right upper chest.	d 10/4/10 at 10:00 A.M., d DON (Director of Nursing) of needed to be removed" mentation in the clinical record ent's PICC line was assessment was completed at val of the PICC line. with the Director of Nursing M., she indicated there was an assessment related to ICC line. with the Director of Nursing M., she indicated she was ved the PICC line, and she assessment of the resident d for Resident # 125 was at 12:05 P.M. Diagnoses for but were not limited to, e. d 11/26/10 at 9:30 P.M., sident) to start dialysis d 12/5/10 at 7:00 P.M., urned to facility Res has an ort on R (right) upper	F	272			

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		155121	B. WIN	1G _	•	02/04/2011	
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	AYETTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ge 22	F	272			
	(MAR) for 12/10 and to assess the reside and thrill every shift initialed as complete During an interview 4:20 P.M., she indic the right side of his would check the site	cation Administration Record d 1/11 indicated the staff were ent's access site for a bruit. This assessment was ed during 12/10 and 1/11. with RN # 3 on 1/27/11 at eated the resident had a port to chest. She indicated you e to ensure there was no ated she would also look for					
	with the Assistant D at 4:22 P.M., she incresident's chest look could not confirm thi	on of the site and interview irector of Nursing on 1/27/11 dicated the site on the ked like an AV shunt, but is because of the dressing would assess for a bruit and fection.			·		
	on 1/28/11 at 11:20 resident's dialysis ac jugular line. She ind to assess the site fo indicated the site she and bleeding, but no indicated she unders	with the Director of Nursing A.M., she indicated the cess site is an internal dicated staff would not be able r a bruit and thrill. She ould be assessed for pain of a bruit and thrill. She stood it was a concern that and an incorrect assessment.		:			
	reviewed on 1/28/11 the resident included gastroesophageal re and hypothyroidism.						!
	Review of a quarterly	y minimum data set					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLI LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155121	B. WII	4G		02/0	04/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	AYETTE		190	ET ADDRESS, CITY, STATE, ZIP CODE 3 UNION STREET FAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	A current care plan 1/15/11, indicated the constipation related medications. Intervindicated staff were bowel function and a ordered. The care pabdominal assessm sounds, abdominal ordenders. Review of the physical 2/11, indicated the reorders for bowel main Milk of Magnesia (a mouth once daily as Bisacodyl suppositor needed for constipation Review of the "ADL" (Record" for 12/10, in have a bowel movem 12/15/10. Review of the Medical (MAR) indicated the powel management period.	10/15/10, indicated the inent of bowel. for the resident, initially dated he resident was at risk for to decreased mobility and entions related to this concern to monitor the resident's administer medications as plan also indicated an ent would include bowel distension, hyper or bunds, and abdominal pain	F 2	272			
; 1 ; 4	to indicate the nursing	g staff completed an ent of the resident during the		The state of the s			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
(155121	B. WII	1G _		02/0	4/2011	
	PROVIDER OR SUPPLIER.	AYETTE		1	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 272	Continued From pa	ge 24	F	272				
	on 1/28/11 at 4:11 F staff should have coassessment at the tabowel movement. looked at the clinical report sheets, and sidocumented assess facility did not have a 5. The clinical recorreviewed on 01/26/2 Diagnoses included, (kidney) failure, severe	with the Director of Nursing P.M., she indicated the nursing empleted an abdominal ime the resident did not have. She indicated she had I record and the 24 hour the was not able to find a sment. She indicated the a bowel management policy. Indicated the at the second and the						
	ulcer, right lower ext (blood clot), hyperter and depression. A dietary progress mindicated, "Res (resin hospitalJan (Janual (pounds); Dec (Dece	remity, deep vein thrombosis nsion (high blood pressure), ote, dated 01/07/2011, dent) currently in ary) 2011 wt (weight) 154 # ember) 2010 157 #; Oct #. Sig (Significant) wt.						
:	indicated "Return fro Documentation was	n form, dated 01/11/11, m Hospital" lacking to indicate that the e resident upon return from						
	the DoN (Director of	on 01/27/2011 at 9:00 a.m., Nursing) indicated the assessed the resident upon ital.						

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AINU FLAIN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING _		COMPLI	
		155121	B. WIN	G		02/0	4/2011
NAME OF	PROVIDER OR SUPPLIER			STREET AD	DRESS, CITY, STATE, ZIP CODE	0210	4/2011
ROSEW	ALK VILLAGE AT LAF	AYETTE			ION STREET		
				LAFAYE	TTE, IN 47904		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI .TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 272	72 Continued From page 25 F 272						
	the dietitian indicate assessment and the completed when the facility.	on 01/27/2011 at 9:30 a.m., d she missed doing the at it should have been e resident returned to the					
	dated 12/00, was proposed policy indicated, "	"Nutrition Risk Assessment," pvided by the dietitian. The lutrition Risk Assessment will (SIC) each significant					
	3.1-31(a) 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS			′6 Leas	6 Quarterly Assessments St Every 3 months the practice of this facil		
,	quarterly review instr	s a resident using the rument specified by the State IS not less frequently than		asses revie State	ess residents using the que instrument specified and approved by CMS tently than once every 3	by the not less	
	by: Based on record revi failed to ensure asse	ew and interview, the facility ssments were updated at of 24 residents reviewed for ts in a sample of 24		acco foun	at corrective action(s) with the second state of the second secon	idents	
	residents (Resident # Findings include:	[‡] 148).		•	Resident #148 has a prisk assessment which current status.	ressure h reflects	
	weakness, renal (kidrobstructive pulmonar			resid affec pract	will you identify other ents having the potent ted by the same deficie tice and what correctiv	ial to be ent	

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1903 UNION STREET ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 276 Continued From page 26 F 276 cells), dermatitis (inflammation of the skin), and Residents who reside in the cellulitis (skin infection). facility have the potential to be affected by the alleged Documentation was lacking to indicate a quarterly pressure wound risk assessment was completed deficient practice. within 92 days of the previous assessment. A Nurse Managers will be repressure wound risk assessment, dated educated on completion of 09/18/2010, indicated the resident was at risk for quarterly assessments by developing skin breakdown. Director of Nursing/designee A care plan, dated 11/08/2010, identified risk for by March 4, 2011. skin break down. Interventions included, but were not limited to, "...HEEL OFF LOADING What measures will be put into BOOTS TO BILATERAL WHEN IN place or what systemic changes you BED...Reposition at least every two hours...LOW AIR LOSS MATTRESS WITH BOLSTERS ' will make to ensure that the deficient practice does not recur? A 60 day scheduled MDS (Minimum Data Set Assessment), dated 12/19/2010, indicated the • MDS Coordinator will provide resident is totally dependent on two staff for bed mobility and transfers. The assessment indicated a list of the assessments the resident had three Stage 2 pressure ulcers required to be completed each (bilateral buttocks and left lateral foot). month to Director of Nursing. • Medical Records Clerk will During an interview on 01/27/2011 at 2:00 p.m., the DoN (Director of Nursing) indicated there had ensure that the assessment been no pressure assessment completed since packets are provided to the 09/18/2010. Nurse Managers. Nurse Managers will complete During an interview on 01/27/2011 at 4:25 p.m.. RN # 3 indicated resident assessments are the assessments by the supposed to be completed quarterly. designated date. MDS Coordinator/designee is

Page 2-30 of CMS's RAI Version 3.0 Manual was

provided by the DoN on 01/28/2011 at 3:00 p.m., as a facility policy for quarterly assessments. The

...must be completed at least every 92 days...It is

manual indicated, "The Quarterly assessment

used to track a resident's status between

responsible to ensure

procedure.

compliance with facility

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- An "Assessment" CQI tool will be completed weekly times four weeks then monthly times two months then quarterly thereafter.
- The CQI committee will review the data gathered and if threshold is not achieved, an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION) DATE SURVEY COMPLETED	
		155121	B. WIN			02/0	4/2011	
	PROVIDER OR SUPPLIER			19	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904	<u> </u>	4/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 282 SS=E	indicators of gradual are monitored" 3.1-31(d)(3) 483.20(k)(3)(ii) SER PERSONS/PER CATTHE SERVICES provided by accordance with eactore. This REQUIREMENT by: Based on observation interview, the facility orders were followed blood pressure and urine specimen, confrestrictions, and presinterventions. This capacity of the service were followed by: 124 residents reviewed orders in a sample of #26, #34, and #134) Findings include: 1a. Resident #26's ranged for the service of the service were followed by: 1a. Resident #26's ranged for the service were followed by: 1b. The services provide by: 1c. The services provided by: 1c. T	RVICES BY QUALIFIED ARE PLAN ded or arranged by the facility y qualified persons in ch resident's written plan of a related to medications, pulse monitoring, obtaining a mpression stockings, fluid ssure ulcer prevention deficient practice effected 5 of ed for completed physician's of 24. (Residents # 11, #19, arranged by the facility y qualified persons in ch record review, and a related to medications, pulse monitoring, obtaining a mpression stockings, fluid ssure ulcer prevention deficient practice effected 5 of ed for completed physician's of 24. (Residents # 11, #19, arranged by the facility of the prevention deficient practice effected 5 of ed for completed physician's of 24. (Residents # 11, #19, arranged by the facility of the prevention of the preve	F 2	282	F282 Services by Qualified Persons/Per Care Plan It is the practice of this facil ensure services are provided arranged by the facility to be provided by qualified person accordance with each resider written plan of care. What corrective action(s) vaccomplished for those resident deficient practice? • Resident #26 the physical was notified in regard omission of the nebulat treatments, blood prechecks and pulses. • Resident #11 receives as per physician order. • Resident #34 wears he stockings per physicial orders. • Resident #134 has blue loading boots to wear per physician orders.	lity to l or e ns in nt's will be idents d by the sician ds to the lizer essure eservices ers. er tenso an e off		

02/04/2011
ON (X5) D BE COMPLETION PRIATE DATE
al to be nt e action in the tial to ged in vices ent are rch 4, e ling per ement and on their
all the received and th

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED	
/4 /4 Na 1		155121	B. WING		02/0	04/2011	
	PROVIDER OR SUPPLIER ALK VILLAGE AT LA	FAYETTE	S	TREET ADDRESS, CITY, STATE, ZIP COI 1903 UNION STREET LAFAYETTE, IN 47904	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	resident received a treatment at any tire 12/31/10. Docume the resident receive per day as ordered 1/1/11 through 1/27 nebthree (3) time on the Medication / indicated "PRN." A nebulizer treatment MAR indicated the nebulizer treatment 1/4/11. Document the resident receive treatment at any time 1/27/11. Document the resident receive per day as ordered During an interview (DoN) and the Corper day as ordered During an interview (DoN) and the Corper day as ordered During an interview (DoN) and the Corper 1/28/11 at 3:10 p.m. should have gotten treatments three time admitted. The DoN why the medication (as needed) order. Incoate a physician's nebulizer had been medication to a PRN she understood the following physician's nebulizer.	and once on 12/5. Is lacking to indicate the my Albuterol nebulizer one from 12/6/10 through ontation was lacking to indicate ed the nebulizer three times by the physician. If 11: "Albuterol 0.083% is daily" A handwritten note administration Record once on 1/1/11 and once on ontion was lacking to indicate ed any Albuterol nebulizer in from 1/5/11 through the treation was lacking to indicate in the day and the nebulizer three times	F 28	What measures will be place or what systemic c will make to ensure that deficient practice does not be a not be placed or what systemic c will make to ensure that deficient practice does not be a not be placed on the system of	the ot recur? re-taff nee, in g devices ipment are ll assure re sheets changes ough ll check the stration per week orders are d. sectoration ipon hire nual, to ponsible to		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SI COMPLE		
·. ·		155121	B. Wii	NG _		02/0	4/2011	
	ROVIDER OR SUPPLIER	AYETTE	•	1:	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	through 1/27/11, ind "Check BP (blood per day)" 11/2/10 through 11/3 the MAR indicated "pressure medication Documentation was pressures were take physician on 11/3, 1 11/28. 12/1/10 through 12/3 the MAR indicated ". Documentation was pressures were take physician on 12/3, 12/14, 12/17, 12/19, and 12/30. 1/1/11 through 1/27/lacking to indicate the taken TID as ordered 1/11, 1/12, 1/13, 1/16/1/25, 1/26, and 1/27. During an interview were taken three times per should have been do had not been done.	Resident #26, dated 11/2/10 dicated the following: pressure) TID (three times 30/10: A hand written note onsee Lisinopril (blood in) BID (two times per day)" lacking to indicate the blood in TID as ordered by the 1/6, 11/9, 11/19, 11/20, and 31/10: A hand written note onsee Lisinopril BID" lacking to indicate the blood in TID as ordered by the 2/4, 12/6, 12/7, 12/11, 12/12, 12/22, 12/23, 12/28, 12/29, 11: Documentation was blood pressures were dispersed by the physician on 1/2, 1/5, 5, 1/17, 1/19, 1/20, 1/24, with the Director of Nursing 1/28/11 at 12:00 p.m., ressure was ordered to be reday. They indicated it ne three times per day and it They indicated it was a see Lisinopril BID" on the	F	282	How the corrective action(s monitored to ensure the def practice will not recur, i.e., quality assurance program put into place? • A "MAR/TAR" CQI to be utilized three times week for one month the weekly thereafter. • Licensed nurse skills validation for g-tube medication administration will be completed week times four weeks, more times two and quarters thereafter. • A "Special Equipment/CQI tool will be utilized times per week times of month, weekly times to month, weekly times to months then quarterly thereafter. • The CQI committee will review the data gathere if threshold is not achieved action plan may be deveroned. • Noncompliance with far procedure may result in employee re-education disciplinary action, up including termination.	cility and/or		
į į	During an interview w	ith the DoN and the		į			ļ	

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID łD PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 282 Continued From page 31 F 282 Compliance date: March 4, 2011 Corporate Nurse Specialist on 1/28/11 at 3:10 p.m., they indicated they were unable to locate any further information related to the blood pressures. They indicated the blood pressures should have been taken three times per day as ordered by the physician. 1c. Review of the Medication Administration Records (MAR) for Resident #26, dated 11/2/10 through 1/27/11, indicated the following: "...Digoxin (a heart medication) 125 mcg (micrograms) i (one) po (orally) qd (daily). Hold if pulse < (less than) 60...9 a.m....' 12/1/10 through 12/31/10: Documentation was lacking to indicate the pulses were taken at 9 a.m., prior to the administration of the medication as ordered by the physician on 12/21, 12/23, 12/24, and 12/30. A care plan, dated 11/2/10, indicated "...problem...at risk for adverse drug reaction, resident receives digoxin...approach...administer meds as ordered...check apical pulse prior to administering medication...." During an interview with the Director of Nursing (DoN) and RN #3 on 1/28/11 at 12:00 p.m. indicated the pulse should have been taken daily prior to the administration of the digoxin at 9 a.m.

During an interview with the DoN and the Corporate Nurse Specialist on 1/28/11 at 3:10 p.m., they indicated they were unable to locate any further information related to the pulses. They indicated the pulses should have been taken daily as ordered by the physician prior to the administration of the 9 a.m., digoxin.

<u> </u>	to to the contract	CAMEDIONIO OLIVIOLO				OND NO	. บองด-บงอ เ
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
- 4	155121		B. WING			02/04/2011	
NAME OF F	PROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE		
ROSEW	ALK VILLAGE AT LAF	AYETTE		1	1903 UNION STREET LAFAYETTE, IN 47904		
OVA ID	SHAMADV STA	TEMENT OF DEFICIENCIES					·
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIES OF T	ULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 32	F 2	282			
	2. The clinical reco reviewed on 2/4/11	rd for Resident # 11 was at 9:55 A.M.					
:	resident was to have sensitivity (laborator presence of a urinary possible urinary trace documentation on the indicate the nursing specimen utilizing at A nursing note, date indicated, "urine speciatheter tolerated properties of the properties of	d 12/29/10 at 10:15 P.M., ecimen obtained via straight occdure well" with the Director of Nursing .M., she indicated the staff cian's order to use a straight e urine specimen. She would always obtain an order they are going to obtain a hight catheter. d for Resident # 34 was					
	history of CVA (strok	but were not limited to, e), degenerative joint elling) and history of cellulitis					
	Physician's Recapitu "RESIDENT TO W STOCKINGS (compi BILATERAL LOWEF DAILY TO DECREA	orinted on the 02/2011 lation indicated, EAR TENOSCHAPE (SIC) ression stockings) ON R EXT (extremities [legs]) SE EDEMA, RESIDENT TO DURING DAY OFF AT					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155121			(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		B. WIN	G	02/0	02/04/2011		
]	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	FAYETTE		STREET ADDRESS, CITY, STATE, ZIP 1903 UNION STREET LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From page 33		F 28	82			
		ion on 02/04/2011 at 11:50 was observed in bed without ockings in place.					
!	Documentation on t 02/04/2011 at 11:52 were in place.	he daily treatment record on 2 a.m., indicated the stockings					
: :	RN # 19 indicated he record indicated she the resident. The R were not in place are putting them on the stockings were loca and applied after the	on 02/04/2011 at 11:55 a.m., er initials on the treatment e had placed the stockings on N indicated the stockings and that she did not remember resident earlier. The ted in the resident's closet e ADoN verified the stockings at that they should have been heet was initialed.					
	reviewed on 01/26/2 Diagnoses included, (kidney) failure, seve venous stasis (slow ulcer, right lower ext	but were not limited to, renal ere protein malnutrition, blood flow through veins) remity, deep vein thrombosis nsion (high blood pressure),					
	and depression. A physician's order,	dated 10/28/2010, indicated wear blue off loading boots at					
	The MDS (Minimum dated 12/01/2010, in at risk for pressure u	Data Set) Assessment, dicated Resident # 134 was licers.					
	A care plan for keepi	ing resident free from further					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
<u>(</u>		155121	B. WING		02/04/2011		
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE				190	ET ADDRESS, CITY, STATE, ZIP CC 13 UNION STREET FAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	"ROUTINELY SO ORDERED AND Prordered" During observation: and 4:25 p.m., 01/26/20 4:00 p.m., and 01/2 resident was observed buring an interview RN # 3 indicated the wearing off loading. During an interview LPN # 1 indicated s resident's off loading buring an interview LPN # 1 indicated s resident's off loadinnew pair. 5. The clinical recorreviewed on 01/26/20 Diagnoses for Resident indicated to, CHF (diabetes type 2, and red blood cells), altered blood cells), altered blood cells), altered blood cells), altered blood cells), afailure. Physician's orders processors and the server processors are processors and the server processors and the server processors are processors and the server processors are processors and the server processors are processors and the server processors and the server processors are processors and the server processors and the server processors are processors and the	ated 12/06/2010, indicated CHEDULED TX (treatment) AS reventative (SIC) treatment as as on 01/24/2011 at 11:30 a.m., 25/2011 at 11:00 a.m., and 211 at 9:00 a.m., 1:00 p.m., 27/2011 at 9:00 a.m., the wed without off loading boots. I on 01/27/2011 at 9:00 a.m., e resident should have been boots but none were in place. I on 01/27/2011 at 9:05 a.m., the could not locate the g boots and had to obtain a ard of Resident # 19 was 2011 at 10:45 a.m. I dent # 19 included, but were (congestive heart failure), emia (decreased number of	F 28	82	DEFICIENCY)		
	(cubic centimeters)FLUSH TUBE PR MEDICATION ADM WATERFLUSH TI TIMES DAILYSUF	FLUID RESTRICTION IOR TO AND AFTER INISTRATION WITH 30 CC UBE WITH 240 CC THREE PLENA VANILLA 8 OZ (hour) X (times) 24 HRS					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		TOTAL TOTAL TOTAL TOTAL CONTROL CONTRO	A. BUI	LDING	COMPL	EIED	
·		155121	B. WING		- 02/0	02/04/2011	
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	FAYETTE		STREET ADDRESS, CITY, STATE, 2 1903 UNION STREET	· · · · · · · · · · · · · · · · · · ·		
		71.61		LAFAYETTE, IN 47904	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X5) COMPLETION DATE	
F 282	Continued From pa	ge 35	F 2	282			
	the RD (Registered not include flushes) calculating the reside indicated the reside of fluid per day. During an interview the corporate nurse facility did not have and that the facility in physician orders for 3.1-35(g)(2) 483.25 PROVIDE C. HIGHEST WELL BE Each resident must provide the necessa or maintain the higher mental, and psychos accordance with the and plan of care. This REQUIREMENT by:	ARE/SERVICES FOR EING receive and the facility must ry care and services to attain est practicable physical, social well-being, in comprehensive assessment	F3	F309 Provide Care/S Highest Well Being It is the practice of thi ensure each resident re necessary care and ser or maintain the highes physical, mental, and well being, in accorda comprehensive assess of care. What corrective actic	s facility to eceives the rvices to attain at practicable psychosocial nce with the ment and plan		
	failed to ensure a res management interve time without a bowel practice affected 1 of	ew and interview, the facility sident received bowel ntions following a period of movement. This deficient 24 residents reviewed for n a total sample of 24		accomplished for tho found to have been a deficient practice?	se residents ffected by the		
	residents. (Resident			Resident #116 h assessment that completed with	t was	70 000	

	IT OF DEFICIENCIES	& MEDICAID SERVICES			OMB NO. 0938-039		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE S	(X3) DATE SURVEY COMPLETED	
		155121	B. WING				
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF			REET ADDRESS, CITY, STATE, ZIP COD 1903 UNION STREET LAFAYETTE, IN 47904		04/2011	
(X4) ID PREFIX TAG	LACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	The clinical record for reviewed on 1/28/12 the resident include gastroesophageal reand hypothyroidism. Review of a quarter assessment, dated resident was inconting of the time. A current care plant 1/15/11, indicated the constipation related medications. Interveindicated staff were bowel function, notify movement by the 3rd medications as order. Review of the physic 2/11, indicated the reorders for bowel man Docusate sodium (a milligrams by mouth of Milk of Magnesia (a la mouth once daily as resident of the "ADL" (a Review of the "ADL")	or Resident # 116 was I at 11:40 A.M. Diagnoses for Id, but were not limited to, eflux disease, hypertension, y minimum data set 10/15/10, indicated the nent of bowel all or almost all for the resident, initially dated e resident was at risk for to decreased mobility and entions related to this concern to monitor the resident's or the physician if no bowel diday, and administer red. ian's order summary for sident had the following lagement: stool softener) 200 once daily at bedtime exative) 30 milliliters by needed for constipation	F 309	maticiani D il	every two ner ential to be cient tive action e at the tential to alleged iewed all o ensure any bowel been re- bowel Staff ee by at into anges you he		

- Bowel/Bladder records will be reviewed in morning meeting (Monday thru Friday) to ensure that residents are not having bowel issues.
- Licensed Nurses will check BM records on a daily basis.
- Certified Nursing Assistants will be re-educated to report to their charge nurse, residents with no BM's for two days or greater by the Staff Development Coordinator/designee by March 4th, 2011.
- A bowel assessment will be completed on residents who don't have a bowel movement for three days. Medications will be administered per orders and physician will be notified on day 4 if still no bowel movement occurs.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				. 0938-039
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	ULTIPLE CONSTRUCTION DING	(X3) DATE S	URVEY
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NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP COD		4/2011
ROSEW	ALK VILLAGE AT LAI	FAYETTE		1903 UNION STREET LAFAYETTE, IN 47904	t.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Review of the Medi (MAR) indicated the bowel management period. There was no document	cation Administration Record e resident did not receive any at interventions during that time mentation in the clinical record	F 30	tool will be utilized per week times one weekly times two m quarterly thereafter. • The CQI committee	two times month, nonths then will	
	abdominal assessmadministered bowel during the time she movement. During an interview	ng staff completed an nent of the resident or management interventions did not have a bowel with the Director of Nursing		review the data gath if threshold is not ac action plan may be a Noncompliance with procedure may result employee re-education	chieved an developed. facility lt in	
assessment at the tir a bowel movement. looked at the clinical report sheets, and sh documented assess administered bowel n She indicated typicall bowel the resident wo Magnesia and then o bowel movement the another intervention.		Impleted an abdominal ime the resident did not have She indicated she had record and the 24 hour he was not able to find a ment or where staff had management medications. Illy after the third day with no rould receive Milk of the fourth day with no resident would receive She indicated the facility did		disciplinary action, including termination. Compliance date: March 4	on.	
F 315 SS=2	3.1-37(a) 483.25(d) NO CATH RESTORE BLADDE Based on the resider assessment, the faci resident who enters to ndwelling catheter is resident's clinical cor	ETER, PREVENT UTI, R nt's comprehensive lity must ensure that a	Mg/ F31	F315 No Catheter, Preven Restore Bladder It is the practice of this facil ensure that a resident who e facility without an indwellin catheter is not catheterized	lity to enters the	

who is incontinent of bladder receives appropriate

resident's clinical condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
(155121	B. WING _		02/04/2011		
	ROVIDER OR SUPPLIER	FAYETTE		REET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 315	This REQUIREME by: Based on record refailed to ensure a rinfection received presulted in an increagitation for the reseffected 1 of 4 resi	ices to prevent urinary tract	F 315	demonstrates that catheteriz necessary; and a resident which incontinent of bladder receis appropriate treatment and so prevent urinary tract infection restore as much normal black function as possible. F315 IS BEING DISPUTE FOLLOWING IS THE PL CORRECTION.	no in ves ervices to ons and to dder		
	at 10:00 a.m. Diag included, but were recurrent UTI (urina dementia. A care plan, dated "problemresider urinary tract infection fluids, assist with in remind resident of psigns/symptoms of urine, c/o (complain burning with urination fever, change in meabnormal findings at A physician's order, "straight cath (urinal demands of the complete	nt has a history of chronic onapproachencourage continent care if needed, proper cleaning, observe for UTI: cloudy/foul smelling ts of) frequency, urgency, or on, abdominal or flank pain, ental status, document nd notify MD" dated 12/27/10, indicated pary catheterization) for UA/		What corrective action(s) accomplished for those refound to have been affected deficient practice? • Resident #26 was treatibilities. Resident diagnosis of Chronic Tract Infections. How will you identify other residents having the potential to be affected by the same deficing practice and what correct will be taken?	ated with at has a c Urinary er action		
	C+S (urinary cathet	erization/cultures and" A care plan attached to		potential to be affec alleged deficient pra			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	IULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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· 		155121	B. WING			02/04/2011	
NAME OF	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	7/2011
ROSEW	ALK VILLAGE AT LAF	FAYETTE		1	903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	increased (arrow up confusioninterven UA/C+S" The Interdisciplinary indicated the followi "12/23/10 9:35 am pm res attempted to downstairs for bowli roommate does not about her roommate club room @12:30 p going to wait there for until 2 pm. Res refu stayed in club room when it started. Teal been increasingly conotifying MD for UA "1/5/11 9:30 amor yelling @ the nurse of meds p (after) nurse Res is just started or to) UTI" "1/7/11 9 amon 1 talking to CNA res sat they really aren't true ppl (people), feels ppd discussed res is bein Review of the nurses documentation was laincreased confusion in the started confus	ers indicated "problem of agitation, anxiety + tionsstr (straight) cath/ I team progress notes ng: Ion 12/22/10 @ (at) 12:30 take her roommate ng staff explained that her bowl. Res became agitated e not going. Res went down to om et (and) stated she was or bowling which didn't start sed to go upstairs & eatres until bowling but then left im discussed that res has enfused. Team discussed C&S" In 1/4/11 @ 9:40 pm res was add t stated she didn't get her had just given her the meds in Septra DS x 5 days d/t (due) I/6/11 @ 11:30 pm res was add she sees things, know are Res says she sees naked of are out to get her. Team ag treated for a UTI"	F	315	 Licensed nursing staff educated on lab follow physician notification condition changes and monitoring for signs a symptoms of UTI's; leads to symptoms of UTI's; leads to coordinator/designeed March 4, 2011. What measures will be put place or what systemic charwill make to ensure that the deficient practice does not a significant practice does not a needed; Certified Nural Assistants are re-educated peri-care, hydration and toileting. Quarterly licensed nursistaff will complete a hydration and toileting assessment on resident Lab orders are reviewed morning clinical meet (Monday – Friday). Lab binders will be brothe morning clinical met (Monday – Friday) to for the completion of I 	w thru, n of d and by the by into nges you e recur? ad as rsing cated on and sing g ats. d in the ing bught to neeting review labs.	
1	obtain the UA/C+S.				 Requisitions will be con at the time of collection 	mpleted n.	

-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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• ;		155121	B. WING		02/04	4/2011
	ROVIDER OR SUPPLIER	FAYETTE		REET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	"12/27/10 9a, res up) anxiety + (and) "12/28/10 9:30 p. Awaiting lab pick up pain or discomfort lacking to indicate if assessment having Documentation was the resident was ex or confusion. Documentation was from 12/28/10 through the resident was experiented to fluid consumentation was the resident was experiencing and complete lacking to indicate wexperiencing agitation." "12/30/10 2:45 p.m. M.D. Awaiting C+S when available" indicate fluid consumption to indicate wexperiencing agitation. A laboratory result of the for Resident #26 day was a hand written that been faxed the murses' notes complete in the consumer	mindicated the following: has had increased (arrow agitationconfusion" m., UA/C+S obtained. 0 (no) c/o (complaints of) " Documentation was luid consumption or urinary been completed. Is lacking to indicate whether periencing agitation, anxiety, stacking in the nurses notes' agh 12/30/10 at 2:45 p.m., aumption or urinary been completed. Is lacking to indicate whether periencing agitation, anxiety, m., UA results returned from the colony count. Will fax MD Documentation was lacking to motion or urinary assessment eted. Documentation was lacking to motion or urinary assessment eted. Documentation was contained the resident was contained anxiety, or confusion. C+S laboratory results sheet the description of 12/31/10. Sontinue:	F 318	 Notify lab and docume the 24 – hour report. When lab results return physician for clinical DNS/designee is responsance compliance with facility procedure. How the corrective action(smonitored to ensure the delipractice will not recur, i.e., quality assurance program put into place? A "Lab Diagnostic" Convill be utilized weekled one month, monthly that two then quarterly the two then quarterly the review the data gather if threshold is not ach action plan may be defined in the procedure may result employee re-education disciplinary action, up including termination. Compliance date: March 4, 2 	n notify course. nsible to th) will be icient what will be QI tool y times imes creafter. Ill red and ieved an veloped. acility in n and/or to and	
-	"1/1/11 2pmATE signs) 128/74, 60, 1	For UTI continues. VSS (vital 8, 98.2" Documentation			:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M(A. BU(ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	FAYETTE		STREET ADDRESS, CITY, STATE, ZIF 1903 UNION STREET LAFAYETTE, IN 47904			
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	prescribed antibiotic this time. Documer fluid consumption of been completed. Do indicate whether the agitation, anxiety, o "1/2/11 11 amre by someone last nig in the hall talking ab most of the time + v her she said no. Re the 12/28/10. MD n anything + we are s count. MD said to g on Mondayongoin Documentation was physician was made of the C+S and colo was lacking to indicate being addressed or been completed. A full investigation in rape was reviewed as	cate the physician had cost to treat the resident's UTI at intation was lacking related to be resident was experiencing reconfusion. The stated that she was raped ght + she heard other people when asked if anyone touched as had U/A + lab work done otified + said not to do till awaiting C+S + colony get with SS (social services)	F3	15			
:	related to fluid status	lacking in the nurses' notes sor a urinary assessment ted from 1/2/11 at 11:00 a.m., 00 a.m.					
; ;	'Septra DS (antibio (two times per day) >	dated 1/3/11, indicated otic) i (one) po (orally) BID (times) 5 days for UTI"		:			
f ! !	i ne nurses' notes in	dicated the following:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL _DING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155121	B. WING			02/04/2011	
NAME OF PROVIDER OR S		FAYETTE		190	ET ADDRESS, CITY, STATE, ZIP 3 UNION STREET FAYETTE, IN 47904		
PREFIX (EACH D			ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
for UTI. To (adverse rewas lacking urinary assent the resider or confusion."1/4/11 7 s/s (signs/s Documents consumption been compaindicate what agitation, as where the consumption been compaindicate what agitation is a consumption been compaindicate what agitation is a consumption between compaindicate what agitation is a consumption between consumptions are consumptions.	la (a.m.). (tempera eactions) g related sessment ation was not was expensed in the sessment ation was expensed in the sessment ation was expensed in the sessment ation was expensed in the sessment at a many control of the sessment at a many con	on ATB (antibiotic) therapy ture) 97.1. 0 (no) AVR noted" Documentation to fluid consumption or a thaving been completed. It lacking to indicate whether periencing agitation, anxiety,ATB continues s (without) s) adverse effects" It lacking related to fluid rinary assessment having becumentation was lacking to be resident was experiencing or confusion. The continues on ATB-UTI. 0 AVR or discomfort" It lacking related to fluid rinary assessment having ocumentation was lacking to be resident was experiencing or confusion. Res continues on ATB/UTI ain or discomfort" It lacking related to fluid rinary assessment having ocumentation was lacking to be resident was experiencing to be resident was experiencing to be resident was experiencing		115			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	FAYETTE		1903	T ADDRESS, CITY, STATE, ZIP CO UNION STREET AYETTE, IN 47904		04/2011
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F 315	Continued From pa	-	F	315			
	experiencing agitati Documentation was or a urinary assess from 1/6/11 at 2:00 a.m. "1/7/11 12 am, Re negative statements unrealistic fears1: "1/7/11 11 am, Co noted. T 97.4 0 c/o p Documentation was consumption or a ur been completed. Do indicate whether the agitation, anxiety, or Resident #26's weig resident weighed 13 January 2011. An admission nutritic	on, anxiety, or confusion. I lacking related to fluid status ment having been completed a.m., until 1/7/11 at 11: 00 Is up in dining room, making s, repetitive verbalizations, + 1 attention given" Intinues on ATB-UTI. 0 AVR pain or discomfort" I lacking related to fluid inary assessment having ocumentation was lacking to resident was experiencing					
	day for this resident fluids per day. A food/fluid intake re administration record 1/8/11, indicated the following:	would be 1652- 1770 mL's of cord and the Medication ds, dated 12/27/10 through resident consumed the					
: .	12/27: 1760 milliliters 12/28: 1800 mL 12/29: 1800 mL 12/30: 1740 mL 12/31: 1740 mL 1/1: 1440 mL	s (mL)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155121	B. WIN	1G _		02/04/2011	
ĺ	PROVIDER OR SUPPLIER	FAYETTE		19	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904		N-V.,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
:	1/2: 1340 mL 1/3: 1620 mL 1/4: 1260 mL 1/6: 2040 mL 1/6: 2040 mL 1/7: 1680 mL 1/8: 1660 mL Documentation was resident consumed during the days beform having a UTI and during the days beform and the LPN #6, and RN #3 indicated over the waster to call and fax resident concerns. Should have called the resident's UTI. Thave gotten treatment 1/3/11. She indicated the nurse over the weekend wastaff obtain treatment indicated the staff shydration, offering a 2-3 glasses of fluids indicated they would related to encouragine every shift in the nurconsumption sheets would not have been	s lacking to indicate the an increased amount of fluids ore she was identified as uring treatment of the UTI. The Director of Nursing (DoN), and 1/28/11 at 12:00 p.m., weekends the on-call physician any resident concern. The sent a weekend, the staff the physician related to any The DoN indicated the staff the MD to get treatment for She indicated the staff should ent from the physician prior to ed the nurse manager on call was responsible for ensuring int for any infections. She manager in charge at that in terminated. The DoN should have been addressing a water pitcher every shift and is with every meal. They dexpect to see documentation in and offering extra fluids reses' notes and on the intake as They indicated the resident in able to be educated at that aviors and agitation she had	F3	315			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPL	(X3) DATE SURVEY COMPLETED	
A. BUILDING		
155121 B. WING 02/	02/04/2011	
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315 Continued From page 45 An interview with the DoN and the Corporate DNS Specialist on 1/28/11 at 3:10 p.m., indicated there was no specific policy related to UTI prevention and treatment. The DoN indicated standards of practice are utilized such as extra fluids, cranberry juice, perineal care assistance, and prompt physician treatment. The DoN indicated she had "no excuse" for the delay in treatment from the time the C & S was obtained from the lab on 12/31/10 and the ordering of treatment from the physician. During an interview with LPN #10 on 12/31/11 at 8:25 a.m., she indicated assessments for a resident with a UTI included urinary output, color of urine, frequency of urine, urgency with urination, pain with urination, temperature of the resident, and fluids should be encouraged. She indicated all this information should be documentation of urinary assessments and documentation or urinary assessments and documentation related to fluids were lacking for Resident #26. During an interview with LPN #6 on 12/31/11 at 8:35 a.m., she indicated with signs, urinary output, color of urine, frequency of urine, odor of urine, dysuria, pain with urination, and fluids should be encouraged. She indicated all this information should be documented on every shift. She indicated assessments and every shift. She indicated assessments for a resident with a UTI included with 1 included to 1 i		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- 1	MULTIPI ILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		155121	B. Wii	NG		02/0	02/04/2011	
ROSEWA	PROVIDER OR SUPPLIER ALK VILLAGE AT LA			190	EET ADDRESS, CITY, STATE, ZIP CODE 03 UNION STREET 1FAYETTE, IN 47904		14/2011	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	response to antibio acceptance of fluid were not document resident every shift seeing documentat fluids. She indicate assessment and do UTI for Resident # During an interview Manager/Registere a.m., she indicated fluids for resident's She indicated she vidocumentation of fluids.	e, vitals of the resident, tics, pain upon urination, and s. The DoN indicated the staff ing assessments of the . She indicated she was not ion of acceptance of increased ed she had concerns with staff ocumentation related to the 26. with the Dietary d Dietitian on 2/4/11 at 9:00 staff should be encouraging with urinary tract infections.	F	315				
	a.m., she indicated during med pass, w snacks. She indica fluids on the food/flunurses' notes. She	with LPN #2 on 2/4/11 at 9:20 staff were to encourage fluids hile in providing care, and with ted staff were to document id intake sheets, and in the indicated nurses should he resident was receptive to		About and the second of the se				
! ! !	9:25 a.m., she indica UTI the staff encour more fluids. She inc	with CNA # 12 on 2/4/11 at atted when a resident has a age the resident to drink licated the amount of fluids sident would be documented ke sheets.				,		
(10:35 a.m., she indic JTI the staff encour	with CNA # 13 on 2/4/11 at cated when a resident has a age the resident to drink icated the amount of fluids						

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
 (155121	B. WIN	1G		02/0	4/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	AYETTE		STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904			12011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 315	On the food/fluid into During an interview 10:40 a.m., she indi UTI the staff encour more fluids. She ind	with CNA # 14 on 2/4/11 at cated when a resident has a rage the resident to drink dicated the amount of fluids sident would be documented	F3	315			
F 322 SS=D	RESTORE EATING Based on the compresident, the facility who is fed by a nasc receives the appropriate prevent aspiration vomiting, dehydratio	rehensive assessment of a must ensure that a resident o-gastric or gastrostomy tube riate treatment and services pneumonia, diarrhea, n, metabolic abnormalities, al ulcers and to restore, if	F 3	22	F322 NG Treatment/Services- restore Eating Skills It is the practice of this provider to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration, pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities and nasal-pharyngeal ulcers and to		
	by: Based on observation review, the facility factories administered with a gastroaffected 1 of 1 resides	n, interview, and record led to ensure medications ith proper technique for a ostomy tube (g-tube). This ents reviewed for g-tube ation in a total sample of 24 #89).			restore, if possible, normal easkills. What corrective action(s) waccomplished for those resident to have been affected deficient practice?	ill be dents	
:	Findings include: During a medication 8:40 a.m., with RN #9 (DoN) the following w	observation on 1/25/11 at 9 and the Director of Nursing vas observed:			 Resident #89 receives a medication utilizing p technique. Resident is currently engaged in the 	roper	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
14 14.		155121	B. WIN	G_		02/0	4/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	AYETTE		19	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	its own plastic mediathe resident's room on the table next to checked the residuaresident's g-tube and the tube via air bolustresident's g-tube with before beginning the The RN held the resident's medication RN aspirated the medication RN aspirated the medication RN aspirated the medication forcing the medication forcing the medication forcing the medication to the resident's g-tube sequence again. The sequence again. The sequence a third time and told him not to fow the resident's gringe which caused resident's stomach to and mix with the medicated he did this imedicated up in the fee plugged up in the fee	esident #89's medications as ician with each medication in cation cup. The RN entered and placed each medication the resident's bed. The RN il feeding present in the dichecked the placement of s. The RN flushed the h 30 milliliters (mL) of water emedication administration. ident's g-tube in his left hand, and placed the syringe and ecups that contained the h and 10 ml water flush. The edication into the syringe and then placed the syringe tube. The RN pushed on the edication and water to enter. The RN repeated this e RN began to do the same e and the DoN interjected orce the medication and esident's g-tube. The RN nd piston into the resident's e piston from the end of the dithe feeding present in the oraspirate into the syringe dication and water. The RN in an effort to "allow the isier into the tube and not get ding tube." The RN	F 3	22		al to be nt e action -tubes e l ucated stration que via by nto ges you ecur?	
	resident's medication then flushed the resid water and began the During the medication observed repeatedly	three more times until the s were passed. The RN lent's g-tube with 30 mL's of resident's tube feeding. In administration the RN was pulling and placing tension ling tube while trying to		The state of the s	skills validation on g-t medication administra the Staff Development Coordinator/designee, March 4, 2011.	tion by	

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 155121 02/04/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 322: Continued From page 49 F 322 • Upon hire and no less that aspirate the medications from the medication cup annually a skills validation into the syringe. The resident's skin at the q-tube will be completed to ensure insertion site was pulling away from her abdomen competency of g-tube due to the tension in the tube. The resident was observed placing a hand on her abdomen at the medication administration. g-tube insertion site in an effort to keep the tube • DNS/designee is responsible to in place. The RN was observed during the ensure compliance with administration dripping medications and water facility procedure. from the end of the syringe on to the resident's personal items located on the bedside table, on the resident's arm, on the resident's bed linens. How the corrective action(s) will be and on the resident's gown. monitored to ensure the deficient practice will not recur, i.e., what During an interview with the RN immediately following the observation, he indicated he "would quality assurance program will be put into place? not normally push the medications into the a-tube via the piston." He indicated the medications should have been administered via gravity. He • A g-tube skills validation will indicated he was unaware he was pulling on the be completed three times resident's g-tube during the administration. weekly times four weeks, During an interview with the DoN immediately monthly times two and following the observation, she indicated the RN quarterly thereafter by the should have placed the syringe into the resident's Staff Development g-tube and administered each medication and water flush via gravity. She indicated medications Coordinator/designee. and water should never be forced into the g-tube. • The CQI committee will She indicated it is inappropriate to pull or place review the data gathered and tension on a g-tube. She indicated the if threshold is not achieved an medication administration was not done per

g-tube, but it did not hurt her, it was just uncomfortable. She indicated she put her hand over the insertion site to keep the tube from

During an interview with Resident #89 on 1/25/11

at 9:35 a.m., she indicated the RN did pull on the

pulling and ensure the g-tube stayed in place.

Compliance date: March 4, 2011

action plan may be developed.

employee re-education and/or

disciplinary action, up to and

• Noncompliance with facility

procedure may result in

including termination.

facility policy.

DEPAR	RTMENT OF HEALTH	HAND HUMAN SERVICES & MEDICAID SERVICES			PRINTEI FORM	D: 02/14/2011 MAPPROVED
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	TIPLE CONSTRUCTION		0. 0938-0391 SURVEY
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F 323	Continued From pa 3.1-44(a)(2) 483.25(h) FREE OF HAZARDS/SUPER	ACCIDENT	F 32:			
	environment remain as is possible; and e adequate supervision prevent accidents. This REQUIREMEN by: Based on record revisible to ensure that were in place for 1 or	sure that the resident is as free of accident hazards each resident receives in and assistance devices to it is not met as evidenced liew and interview, the facility fall prevention interventions if 6 residents reviewed for 4 residents (Resident # 128).		F323 Free of Accident Hazards/Supervision/Device It is the practice of this facility ensure that the resident environment as free of accident hat is possible; and each resident adequate supervision and assist devices to prevent accidents. What corrective action(s) we accomplished for those resident found to have been affected deficient practice?	y to nament zards as receives stance	
	The clinical record for reviewed on 01/28/20 Diagnoses included, dementia with behaviosteoporosis, arthritis A "Fall Risk Assessmindicated, " the residexperiencing a fall" Nurse's notes, dated indicated, "Res (respect to chair slipped in	but were not limited to, oral disturbances, and depression. ent," dated 11/13/2010, dent is at risk for 01/18/2011 at 10 a.m., ident) was getting up from fluid slipped to floorMD ed orders to sent to ER		• Resident #128 has a fall assessment with intervention that reflect resident's constatus. Resident has fall interventions in place a not experienced any furfalls. How will you identify other residents having the potential affected by the same deficient practice and what corrective will be taken?	entions current ll and has arther al to be	

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 155121 02/04/2011 i... hE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE. IN 47904 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 323 | Continued From page 51 F 323 • Residents who are at fall risk A "Fall Circumstance Report," dated 01/18/2011 have the potential to be at 10:00 a.m., indicated, "... Bed pad alarm. affected by the alleged Gripper socks while in bed..." were interventions deficient practice. put in place to prevent another fall. An "Interdisciplinary Team Progress Note," dated Nursing staff were re-educated 01/19/2011 at 10:00 a.m., indicated, "...Team on following care plan/orders also reviewed that res (resident) will be on 30 min for resident's, by the Staff (minute) checks while in bed d/t (due to) the limitations..." Development Coordinator/ designee, by March 4, 2011. A care plan for "RISK FOR FALLS," dated 01/19/2011, indicated, "...30 min (minute) (symbol What measures will be put into for checks) while in bed to assure safety d/t (due to) limitations (symbol for with) shoulder fx place or what systemic changes you (fracture)...." will make to ensure that the deficient practice does not recur? Documentation was lacking to indicate bed checks had been completed. Licensed nurses round to During an interview on 01/28/2011 at 11:50 a.m., ensure fall interventions are in RN # 3 indicated the documentation for bed place and the safety of our checks should have been in the treatment book. residents throughout their She was unable to locate the documentation. shift. During an interview on 02/04/2011 at 10:15 a.m., • Falls will be reviewed in the the DoN (Director of Nursing) indicated the facility morning clinical meeting was not able to locate documentation of bed (Monday through Friday) checks. She indicated there was no with interventions and care documentation to verify the bed checks had plans updated to ensure changes are made for safety. A policy titled "Fall Management Program," dated Nurse Managers will review 07/01 and reviewed 03/10, was provided by the

future falls...."

DoN on 02/04/2011 at 11:00 a.m. The policy indicated, "...the interdisciplinary team...to

determine other possible interventions to prevent

on the weekends.

Fall risk assessments are

completed at admission, re-

admission, quarterly, annual and with a significant change.

- A fall circumstance is completed with immediate interventions to keep residents safe.
- IDT to review falls in morning clinical meeting (Monday through Friday) to determine interventions and root cause.
- Care plan and nurse aid assignment sheet are updated after each fall to reflect current status.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

- Licensed nurses round to ensure fall interventions are in place and the safety of our residents throughout their shift.
- A "Fall Management" CQI tool be completed weekly times four weeks, monthly times two and quarterly thereafter.

- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES EXAMENT OF DEFICIENCIES (XXX) PROVIDER SUPPLIES (CVA)

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
4		155121	B. WING		02/0	04/2011	
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F 328	The facility must e proper treatment a special services: Injections; Parenteral and ent Colostomy, uretero Tracheostomy care; Tracheostomy care; Foot care; and Prostheses. This REQUIREME by: Based on observatinterview, the facilit received respirator ordered by the physical properties of the proper	MENT/CARE FOR SPECIAL Insure that residents receive and care for the following eral fluids; stomy, or ileostomy care; e; e; e; g; NT is not met as evidenced ion, record review and y failed to ensure a resident y nebulizer treatments as sician due to respiratory medication having been d from a scheduled medication mes per day to PRN (as	F 328	F328 Treatment/Care for Needs It is the practice of this fact ensure that residents receit treatment and care for the special services: injection and enteral fluids; colosto uretrostomy or ileostomy tracheostomy care; traches suctioning; respiratory care care; and prostheses. What corrective action(staccomplished for those in found to have been affect deficient practice? Resident #26 the play was notified in regionission of the neutreatments, blood checks and pulses.	cility to ve proper following s; parenteral my, care; al re; foot s) will be residents red by the hysician gards to the bulizer pressure		
	administration. Thi of 24 resident's rev	n and incorrect oxygen is deficient practice effected 2 dewed for respiratory care and ole of 24. (Residents #19 and		 Resident # 19 received ordered by physical saturations of 92 to percent. Physician notified of altered 	ian, with o 96 n was		
	Findings include:					ļ	
:	1/28/11 at 10:00 a.r #26 included, but w hypothyroidism, ast	ecord was reviewed on n. Diagnoses for Resident ere note limited to, anxiety, hma, GERD reflux disease), dysphagia		How will you identify ot residents having the pot affected by the same def practice and what correwill be taken?	ential to be icient		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S' 1903 UNION STREET LAFAYETTE, IN 479	TATE, ZIP CODE		
(X4) ID PREFIX TAG	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE	
	heart failure), hyp disease, and atria indicated the reside on 11/2/10. Discharge instruct admission, dated was to receive " 3X/day one vial Review of the Med (MAR), dated 11/2 the following: 11/2/10 through 1 neb (nebulizer) tid handwritten note of Administration Red (discontinue) 11/1 resident received the treatment two times on 11/8, and A nebulizer treatment MAR indicated the nebulizer treatment 11/4; two times on 11/8; once on 11/10; once on 11/10 coumentation was resident received at treatment from 11/10 Documentation was resident received to day as ordered by 12/1/10 through 12/1/	ing), history of CHF (congestive extension, coronary artery of fibrillation. Documentation dent was admitted to the facility of the resident's 11/2/10, indicated the resident of the resident received the Albuterol of the resident received the	F3	Residents nebulizer utilize ox potential alleged d. Nursing st educated. Developm Coordina ensuring assessme March 4, What measures place or what sy will make to ensuring deficient practice. The licens physician followed their assis. Nurse March Marc	treatments and / or tygen have the to be affected by the eficient practice. taff were reported by the Staff ment stor/designee, on orders and ents are complete, by 2011. will be put into externic changes you sure that the ce does not recur? The definition of the staff ment story designee is responsible to ompliance with		

PRINTED: 02/14/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING B. WING 02/04/2011 155121 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1903 UNION STREET **ROSEWALK VILLAGE AT LAFAYETTE** LAFAYETTE, IN 47904 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 328 F 328 Continued From page 54 How the corrective action(s) will be handwritten note on the Medication Administration Record indicated "See flow sheet monitored to ensure the deficient PRN." practice will not recur, i.e., what quality assurance program will be A nebulizer treatment flow sheet attached to the put into place. MAR indicated the resident received the Albuterol nebulizer treatment once on 12/2; two times on 12/3; once on 12/4, and once on 12/5. A "MAR/TAR Flow sheet" Documentation was lacking to indicate the CQI tool will be utilized three resident received any Albuterol nebulizer times per week for one month treatment at any time from 12/6/10 through then weekly thereafter. 12/31/10. Documentation was lacking to indicate the resident received the nebulizer three times • An "Oxygen Therapy" CQI per day as ordered by the physician. tool will be utilized weekly times four weeks, monthly 1/1/11 through 1/27/11: "...Albuterol 0.083% times two and quarterly neb...three (3) times daily..." A handwritten note on the Medication Administration Record thereafter. indicated "PRN." The CQI committee will

nebulizer treatment once on 1/1 and once on 1/4. Documentation was lacking to indicate the resident received any Albuterol nebulizer treatment at any time from 1/5/11 through 1/27/11. Documentation was lacking to indicate the resident received the nebulizer three times per day as ordered by the physician.

A nebulizer treatment flow sheet attached to the

MAR indicated the resident received the Albuterol

The nurses notes indicated the following:

"...12/23/10 1 p (p.m.), Res (resident) c/o sore throat, cough, has nasal congestion lungs clear notified MD await reply...." Documentation was lacking related to vitals having been obtained.

"...12/23/10 4:45 pm N.O. (new order) Z-pak (antibiotic) po (orally) ii (two) initial dose, then i

- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	infection)" Docu indicate a respirato been completed. "12/24/10 12 am 97.0. 0 (no) c/o sor breath), cough note pain/discomfort" indicate a lung assebeen completed. Documentation was assessment related use of antibiotic harnurses notes from through 12/25/10 at "12/25/10 9:45 am. (pulse) 68, r (respir pressure)111/68, S on room air. ATB ((without) s/s (signs/Documentation was	4 days/URI (upper respiratory mentation was lacking to ry assessment and vitals had Res resting, quietly in bed. T e throat. 0 SOB(shortness of ed at this time. 0 c/o Documentation was lacking to essment of the resident had Is lacking to indicate any to respiratory status or the documented in the 12/24/10 at 12:00 a.m.,	F	328			
	related to a respirat completed from 12/12/27/10 when the	s lacking in the nurses' notes ory assessment having been 25/10 at 9:45 a.m., through resident completed the e upper respiratory infection.			. •		
	on 1/28/11 at 3:10 p #26 should have go treatments three tim admitted. She indic	with the Director of Nursing o.m., she indicated Resident tten the Albuterol nebulizer nes per day since she was ated she did not know why been changed to a PRN		:			

	FOF DEFICIENCIES OF CORRECTION			COMPLETED		
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	PROVIDER OR SUPPLIER	FAYETTE		STREET ADDRESS, CITY, STATE, ZIP O 1903 UNION STREET LAFAYETTE, IN 47904		
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F 328	order. She indicate physician's order to been changed from PRN by the staff. It the concern related buring an interview 8:25 a.m., she indicated the assest temperature, lung streath. She indicated include any docum respiratory status of the assessments in lacking information every shift. She include been getting times per day.	ed she could not locate a support why the nebulizer had a scheduled medication to a She indicated she understood do to the medication error. With LPN #10 on 12/31/11 at cated assessments should be needed on every shift. She assment should include sounds, cough, shortness of ted the assessment should entation related to the of the resident. She indicated in the resident's chart were and had not been completed dicated the resident should the nebulizer treatments three	F3	28		
	8:35 a.m., she indicof the resident sho She indicated the a information related vitals, sputum produced breath. She indicated done appropriately During an interview on 12/31/11 at 8:40 should have been a respiratory status e assessments shout temperature, cougloxygen, and pain. concerns with the Inursing staff. She	with LPN #6 on 12/31/11 at cated respiratory assessments and have been done every shift. Assessment should include to auscultation of the lungs, fuction, cough, shortness of ted the assessments were not with the Director of Nursing Da.m., she indicated staff assessing Resident #26's every shift. She indicated the ld include lung sounds, n, shortness of breath, need for She indicated she had ack of assessments from indicated she did not have a rovide related to the concerns.				

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE STREET ADDRESS, CITY, STATE, 2P CODE 1993 UNION STREET LAFAYETTE, IN 47904 SUMMARY STATEMENT OF DEFICIENCES LAFAYETTE, IN 47904 FREGULATORY OR LSC IDENTIFYING INFORMATION) FREETY TAG CECAL DEFICIENCY WIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 328 Continued From page 57 2. The record of Resident #19 was reviewed on 01726/2011 at 10-45 a.m. Diagnoses for Resident #19 included, but were not limited to, CHF (congestive heart failure), diabetes type 2, anemia, altered mental status, carcinomyopathy (deterioration of the function of the heart muscle), and acute renal (kidney) failure. A physician's order, dated 10/27/2010, indicated "02 (oxygen) @ at 2 L (liters per minute) per nasal canula (a device used to deliver supplemental oxygen through the nasal passages) A health care plan for ineffective tissue perfusion related to cardiac diagnosis, dated 01/24/2011, indicated, "Observe for and documentshortness of breathabnormal 02 (oxygen) gasts (saturation). Notify MD (medical doctor) During observations on 1/24/2011 at 11:30 a.m., 4:15 p.m.; 01/25/11 at 10 a.m.; 01/25/2011 at 9:20 a.m., 11:00 a.m., 4:20 p.m. and 01/27/2011 at 8:45 a.m., the oxygen was being delivered at 1 1/2 liters per minute and should have been at a delivery rate of 2 liters per minute. During an interview on 01/27/2011 at 2:00 p.m., the DoN (Director of Nursing) indicated the facility did not have a formal policy for oxygen delivery and that the facility referenced the physician's orders to determine the oxygen setting.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		•	(X3) DATE SURVEY COMPLETED	
ROSEWALK VILLAGE AT LAFAYETTE 1903 UNION STREET LAFAYETTE, IN 47904	X ·		155121	B. WII	NG _		02/	04/2011
Canal Desiciency Must are precepted by Full (EACH Desiciency Australe PRECENT ACTION SHOULD BE CONSHIEND IN TAG (CONSHIEND ACTION OF A			-AYETTE		19	903 UNION STREET	E	
2 The record of Resident # 19 was reviewed on 01/26/2011 at 10:45 a.m. Diagnoses for Resident #19 included, but were not limited to, CHF (congestive heart failure), diabetes type 2, anemia, altered mental status, cardiomyopathy (deterioration of the function of the heart muscle), and acute renal (kidney) failure. A physician's order, dated 10/27/2010, indicated "02 (oxygen) @ (at 2 L (liters per minute) per nasal canula (a device used to deliver supplemental oxygen through the nasal passages)" A health care plan for ineffective tissue perfusion related to cardiac diagnosis, dated 01/24/2011, indicated, " Observe for and document shortness of breathabnormal 02 (oxygen) sats (saturation). Notify MD (medical doctor)" During observations on 1/24/2011 at 11:30 a.m., 4:15 p.m.; 01/25/11 at 10 a.m.; 01/26/2011 at 9:20 a.m., 11:00 a.m., 4:20 p.m., and 01/27/2011 at 4:8-5 a.m., the oxygen was being delivered at 1 1/2 liters per minute via nasal canula. During an interview on 01/27/2011 at 9:30 a.m., RN # 1 indicated the oxygen setting was 1 1/2 liters per minute and should have been at a delivery rate of 2 liters per minute. During an interview on 01/27/2011 at 2:00 p.m., the DoN (Director of Nursing) indicated the facility did not have a formal policy for oxygen delivery and that the facility referenced the physician's	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
	F 328	2. The record of Re 01/26/2011 at 10:49 Diagnoses for Resinot limited to, CHF diabetes type 2, and cardiomyopathy (dethe heart muscle), a failure. A physician's order "O2 (oxygen) @ (at nasal canula (a dev supplemental oxygen) assages)" A health care plant related to cardiac dindicated, "Obsershortness of breasts (saturation). No During observations 4:15 p.m.; 01/25/11 9:20 a.m., 11:00 a.m. at 8:45 a.m., the ox 1/2 liters per minute and delivery rate of 2 liters per minute and delivery rate of 2 liters and that the facility	esident # 19 was reviewed on 5 a.m. Ident #19 included, but were (congestive heart failure), emia, altered mental status, eterioration of the function of and acute renal (kidney) I, dated 10/27/2010, indicated to 2 L (liters per minute) per vice used to deliver en through the nasal For ineffective tissue perfusion iagnosis, dated 01/24/2011, ve for and document: withabnormal O2 (oxygen) Notify MD (medical doctor)" Is on 1/24/2011 at 11:30 a.m., at 10 a.m., and 01/27/2011 at m., 4:20 p.m., and 01/27/2011 at m., 4:20 p.m., and 01/27/2011 at evia nasal canula. I on 01/27/2011 at 9:30 a.m., e oxygen setting was 1 1/2 d should have been at a ers per minute. I on 01/27/2011 at 2:00 p.m., of Nursing) indicated the facility al policy for oxygen delivery referenced the physician's	F	328			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER ALK VILLAGE AT LA SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CO 1903 UNION STREET LAFAYETTE, IN 47904 PROVIDER'S PLAN OF COR	DE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
F 329	Each resident's druunnecessary drugs drug when used in duplicate therapy); without adequate rindications for its u adverse consequeshould be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs therapy is necessa as diagnosed and crecord; and resident drugs receive grade behavioral interven	EGIMEN IS FREE FROM DRUGS ug regimen must be free from s. An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F 3:	F329 Drug Regimen is F Unnecessary Drugs It is the practice of this farensure that each resident's regimen is free from unned drugs. An unnecessary drug when used in excess (including duplicate thera excessive duration; or wit adequate monitoring; or wadequate indications for it the presence of adverse consequences, which indicates should be reduced or discontinued; or any combit the reasons above. What corrective action(saccomplished for those residences is provided to the reasons above.	cility to s drug cessary ug is any ive dose py); or for hout vithout s use; or in cate the cinations of		
:	This REQUIREMEN by: Based on record re failed to ensure AIM movement scale) as to monitor for adver Reglan, for 1 of 24 a medications with po	view and interview, the facility also (abnormal involuntary assessments were completed as affects of the medication, residents reviewed for a tential for negative side of 24 residents. (Resident#		found to have been affect deficient practice? • Resident #19 AIMS completed. How will you identify off residents having the pote affected by the same defined practice and what correct will be taken?	was ner ential to be cient		

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 02/04/2011 155121 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1903 UNION STREET ROSEWALK VILLAGE AT LAFAYETTE LAFAYETTE, IN 47904 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE 1D SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Residents who receive F 329 Continued From page 59 F 329 antipsychotic / gastrointestinal 19) medications have the potential to be affected by the alleged Findings include: deficient practice. The clinical record of Resident # 19 was reviewed • Director of Nursing Service on 01/26/2011 at 10:45 a.m. Specialist re-educated the Diagnoses for Resident # 19 included, but were DNS / ADNS on the not limited to, CHF (congestive heart failure), completion of AIMS for diabetes type 2, anemia (decreased number of residents who receive red blood cells), altered mental status, antipsychotic / gastrointestinal cardiomyopathy (deterioration of the function of the heart muscle), and acute renal (kidney) medications, by March 4, failure. 2011. A physician's order, dated 08/24/2010, indicated, What measures will be put into "Metoclopram (Reglan, a medication used to treat place or what systemic changes you heartburn caused by acid reflux) 5 mg (milligram) tab (tablet). Take 1 tablet per PEG (feeding tube) will make to ensure that the tube once daily." deficient practice does not recur? A facility care plan for adverse medication side An audit was conducted by the effects, dated 01/24/2011, indicated, "AIMS (abnormal involuntary movement scale) DNS/designee to ensure that assessment two times a year..." AIMS testing was completed for residents utilizing Documentation was lacking to indicate an AIMS antipsychotic / gastrointestinal assessment had been completed for the resident. medications. During an interview on 01/27/2011 at 2:00 p.m., · The Pharmacist review the DoN (Director of Nursing) indicated the residents' clinical records resident had not had AIMS assessment. monthly for excessive

Event ID: 7TI211

Patient monitoring instructions listed in the "2010

Nursing Spectrum DRUG Handbook" indicated,

movement of face, eyes, or limbs) reactions..."

"Watch for extrapyramidal (involuntary

duration of drug usage,

presence of adverse

consequences.

adequate monitoring and

PRINTED: 02/14/2011

3.1-48(a)(3)

- An AIMS is completed upon admission and every six months thereafter for use of antipsychotic / gastrointestinal medications.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- An "Assessment" CQI tool will be completed weekly times four weeks then monthly times two months then quarterly thereafter.
- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

If continuation sheet 60A of 84

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
: ′		155121	B. WING _		02/04	4/2011
ROSEW	PROVIDER OR SUPPLIER ALK VILLAGE AT LA		1 L	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904 PROVIDER'S PLAN OF CORRECT	TION	,ve.
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
SS=D	This REQUIREME by: Based on record refailed to ensure poerrors did not occunebulizer inhalation mistakenly change to be given three tineeded) medicatio effected 1 of 24 remedication errors i #26) Findings include: 1. Resident #26's 1/28/11 at 10:00 a. #26 included, but whypothyroidism, as (gastroesophageal history of CHF (corhypertension, corolibrillation. Docume was admitted to the	nsure that residents are free of dication errors. NT is not met as evidenced eview and interview, the facility tentially significant medication related to a respiratory medication having been d from a scheduled medication mes per day to PRN (as in. This deficient practice sident's reviewed for significant in a sample of 24. (Resident vere note limited to, anxiety, thma, GERD reflux disease), dysphagia, ingestive heart failure), mary artery disease, and atrial entation indicated the resident of facility on 11/2/10.	F 333	F 333 Residents Free of Simed Errors It is the practice of this facilian ensure that residents are free significant medication errors. What corrective action(s) accomplished for those resident practice? • Resident #26 the physical was notified in regard omission of the nebuliate treatments. Resident currently continues we nebulizer treatments respiratory distress. How will you identify other residents having the potent affected by the same deficit practice and what correctivatile be taken? • Residents who reside	ity to e of any s. will be idents d by the sician ds to the dizer t vith PRN for r tial to be ent ve action	
	admission, dated 1 was to receive "A 3X/day one vial"	ons for the resident's 1/2/10, indicated the resident lbuterol 0.083% nebulizer		facility have the pote be affected by the all deficient practice.	ntial to eged	
9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		cation Administration Records 10 through 1/27/11, indicated		 Nursing staff were re- educated, by the Staf Development 		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
6.							
		155121	B. WII	NG		02/04	1/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	AYETTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		ULD BE	(X5) COMPLETION DATE	
	neb (nebulizer) tid (handwritten note on Administration Reco (discontinue) 11/11, resident received the treatment two times once on 11/8, and once on 11/8, and once on 11/8, and once on 11/10, once on 11/11, two times on times on 11/8; once on 11/11, once on 11	doubtered in a series of the series of indicated the resident received the Albuterol 11/3; three times on 11/4; once on 11/3; two times on 11/4; once on 11/9. Interest of the Albuterol of the resident received the Albuterol 11/5; three times on 11/7; two is on 11/9; three times on 11/7; two is on 11/9; three times on 11/12. It is lacking to indicate the result of indicate the republic of indicate the resident received the Albuterol of indicated "See flow sheet of indicated to the resident received the Albuterol once on 12/2; two times on and once on 12/2; two times on and once on 12/5. It is lacking to indicate the resident received the Albuterol once on 12/6/10 through of indicate in the resident of indicate indicat	F:	3333	Caardinatar/dagignaa	into iges you e recur? in deleted as c, 2011. into iges you e recur? in deleted as colleted as coll	
	the resident receive	d the nebulizer three times by the ohysician			practice will not recur, i.e.,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	(EACH DEFICIENC	FAYETTE ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA		OULD BE	(X5) COMPLETION DATE
F 333	nebthree (3) time on the Medication indicated "PRN." A nebulizer treatment of the nebulizer treatment of the nebulizer treatment of the nebulizer treatment at any time treatment at any time resident received a treatment at any time resident received of the resident received of the resident received of 1/28/11 at 3:10 #26 should have got treatments three time demitted. She indicated the medication had order. She indicated physician's order to been changed from PRN by the staff.	7/11: "Albuterol 0.083% es daily" A handwritten note Administration Record ent flow sheet attached to the resident received the Albuterol t once on 1/1 and once on 1/4. s lacking to indicate the any Albuterol nebulizer me from 1/5/11 through intation was lacking to indicate ed the nebulizer three times	F 333	quality assurance programment into place? • A "MAR/TAR Flow CQI tool will be utilitimes per week for on their weekly thereaf. • The CQI committees review the data gath if threshold is not accompliance with procedure may resure employee re-educate disciplinary action, including termination. Compliance date: March 4	sheet" lized three one month ter. will ered and chieved an developed. facility It in ion and/or up to and on.	
F 406	If specialized rehall not limited to, physical pathology, occupate health rehabilitative and mental retarda	E/OBTAIN SPECIALIZED Solitative services such as, but ical therapy, speech-language ional therapy, and mental e services for mental illness tion, are required in the tensive plan of care, the facility	F 406	F406 Provide/Obtain Spec Rehab Services If specialized rehabilitative such as, but not limited to, put therapy, speech-language proccupational therapy, and number health rehabilitative services	services physical athology, nental	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155121	B. WING		02/04/2011			
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904 ID PROVIDER'S PLAN OF CORRECTION				
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 406	required services to accordance with § provider of special This REQUIREME by: Based on record refailed to ensure a for occupational there of 24 residents rev	age 63 equired services; or obtain the from an outside resource (in 483.75(h) of this part) from a lized rehabilitative services. ENT is not met as evidenced eview and interview, the facility resident with physician orders lerapy was provided the py intervention. This affected 1 riewed for specialized ces in the sample of 24.	F 406	mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource from a provider of specialized rehabilitative services. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?				
	reviewed on 1/25/1 the resident includ- quadriplegia with s	for Resident # 96 was I1 at 10:15 A.M. Diagnoses for ed, but were not limited to, pasticity. y Progress Notes" form, dated		Resident #96 was occupational ther deemed that no statement therapy services at that time. How will you identify a	rapy, but was killed were needed			
	11/8/10, and signed by a physician, indicated, " Needs UE (upper extremity) strengthening. See OT (occupational therapy) order" A physician's telephone order, dated 11/8/10, indicated, "OT: UE strengthening functional exercises"			How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?				
	to indicate the residual therapy services reson 11/8/10. During an interview	umentation in the clinical record dent received occupational elated to the physician's order with the Therapy Manager, on M., she indicated she was not		Residents who have orders for therapy or have a change have the potential affected by the all deficient practice.	y evaluation of condition, I to be leged			

 Therapists have been reeducated by the Regional Rehabilitation Manager on screen procedure and evaluation without treatment procedure, by March 4, 2011.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- Therapy screens to be completed upon admission/readmission and no less than quarterly on all residents.
- Therapy screens to be completed on any resident who is referred by Interdisciplinary Team.
- Admissions and readmissions will be communicated by nursing to therapy utilizing the nursing to therapy communication form.
- Residents with therapy orders will be evaluated by skilled discipline. If resident is evaluated per physicians order, and no treatment is indicated this will be communicated to nursing via

- communication form following evaluation for feedback to physician.
- A copy of this form will be submitted to Executive Director / Director of Nursing Service for review.
- Executive Director/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

- Interdisciplinary Team will review residents during the morning meeting for decline in Activities of Daily Living utilizing the MDS process.
- Clinical Record Audit Tool will be completed upon admission and readmission.
- The CQI committee will review the data gathered and an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155121	B. WING			02/04/2011		
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE				STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENCE		LD BE	(X5) COMPLETION DATE	
F 406	O6 Continued From page 64 aware of the 11/8/10 physician's order for occupational therapy. She indicated the residen was currently on restorative nursing, and at the		F 406		disciplinary action, up including termination.	to and		
	time of the 11/8/10 finished occupation resident was seen splints. She indical have been appropriate time, and no seen appropriate time, and no seen appropriate time.	order, the resident had just hal therapy. She indicated the at that time related to new ted the resident would not hate for occupational therapy at creening or evaluation was all of the physician's order on			Compliance date: March 4, 20	011		
	on 1/28/11 at 4:15 I	with the Director of Nursing P.M., she indicated the therapy creened the resident after the 11/8/10.						
	the Executive Directitled "Screening", in ensure that all residuals	licy, revised 12/09, provided by tor on 1/31/11 at 8:40 A.M., ndicated, "It is our policy to lent who may potentially need es are reviewed, identified and ar basis"						
	3.1-23(a)(1) 483.60(b), (d), (e) E LABEL/STORE DR	PRUG RECORDS, UGS & BIOLOGICALS	F۷	131	F431 Drug Records, Label/st Drugs & Biologicals	ore		
: : : : : : : : : : : : : : : : : : : :	a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order controlled drugs is a reconciled.	nploy or obtain the services of sist who establishes a system that and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically			It is the practice of this facility employ or obtain the services of licensed pharmacist who estable system of records of receipt and disposition of all controlled dru sufficient detail to enable an ac- reconciliation; and determines drug records are in order and the	of a lishes a d ugs in ccurate that		
! !		ils used in the facility must be ce with currently accepted		- 1	account of all controlled drugs			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 431	appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Dructontrol Act of 1976 abuse, except when package drug distrity quantity stored is more readily detected. This REQUIREMENT by: Based on record refailed to ensure 2 stigned off on the demedications, and faplace related to the medications. This of 24 residents review in a sample of 24. (Findings include:	oles, and include the ory and cautionary e expiration date when State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. Ovide separately locked, a compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ainimal and a missing dose can over any of the extruction of narcotic alled to ensure a policy was in destruction of narcotic deficient practice effected 1 of ed for medication destruction Resident # 149 was	F	431	maintained and periodically reconciled. What corrective action(s) waccomplished for those resifound to have been affected deficient practice? • Resident #149 no long resides in the facility. How will you identify other residents having the potent affected by the same deficient practice and what corrective will be taken? • Residents who utilize controlled drugs have potential to be affected alleged deficient practice alleged deficient practice destruction, by the Standard Development Coordinator/designed March 4, 2011. What measures will be put place or what systemic chawill make to ensure that the deficient practice does not	idents I by the ger r tial to be ent we action e the ed by the ctice. e re- otic taff e, by into nges you e	

- When controlled medications are discontinued it must be pulled from the medication cart and destroyed by two nurses.
- Controlled Schedule II medications will be destroyed by flushing down a toilet or hopper.
- Two nurses must witness the destruction of narcotic medication and sign off the "Destruction of Narcotics" form; to include the number of drugs destroyed and date they were destroyed.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?

 A "Medication Storage Review" CQI tool will be utilized two times per week for one month then weekly

STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155121	B. WING		02/04	1/2011
	ROVIDER OR SUPPLIER	FAYETTE	19	EET ADDRESS, CITY, STATE, ZIP CODE 003 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	indicated a nurse of "Morphine Sulfate (pain medication) 20 mL)." Documentat medication destruction destruction of med Nursing on 1/27/11 there was no specificated struction of med During an interview 5:15 p.m., he indicated witness and sign narcotic medication. During an interview 5:18 p.m., she indicated she included to marcotic medicated on 1/28/11 at 5:20 be two nurses to witness to witness to witness to witness to witness to witness and sign narcotic medication of narcotic medication of narcotic medicated she could documentation related stroyed the Morpho specific policy medications. She	ruction Sheet, dated 1/3/11, lestroyed 30 mL (milliliters) of (controlled substance- narcotic mag (milligrams) / mL #30 (30 ion was lacking to indicate the stion was witnessed by another with Assistant Director of at 12:15 p.m., she indicated fic policy related to the ications. With LPN # 8 on 1/28/11 at eated there must be two nurses off on the destruction of ms. With LPN # 30 on 1/28/11 at cated there must be two and sign off on the destruction	F 431	times two months an quarterly thereafter. The CQI committee we review the data gather if threshold is not act an action plan may be developed. Noncompliance with procedure may result employee re-educated disciplinary action, we including termination. Compliance date: March 4.	vill ered and hieved, be facility t in on and/or up to and n.	
F 441 SS=E	3.1-25(o) 483.65 INFECTION SPREAD, LINENS	N CONTROL, PREVENT	F 441	F441 Infection Control, Pr Spread, Linens	event	•

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING B. WING 02/04/2011 155121 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1903 UNION STREET ROSEWALK VILLAGE AT LAFAYETTE LAFAYETTE, IN 47904 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) It is the practice of this facility to F 441 F 441 Continued From page 67 establish and maintain an infection The facility must establish and maintain an Infection Control Program designed to provide a control program designed to provide safe, sanitary and comfortable environment and a safe, sanitary and comfortable to help prevent the development and transmission environment and to help prevent the of disease and infection. development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -What corrective action(s) will be (1) Investigates, controls, and prevents infections accomplished for those residents in the facility, found to have been affected by the (2) Decides what procedures, such as isolation, deficient practice? should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. • Resident #65 and #115 receives blood sugar checks (b) Preventing Spread of Infection utilizing proper infection (1) When the Infection Control Program determines that a resident needs isolation to control technique. prevent the spread of infection, the facility must • Resident #88, #96 and #148 isolate the resident. receives wound care utilizing (2) The facility must prohibit employees with a communicable disease or infected skin lesions proper infection control from direct contact with residents or their food, if technique. direct contact will transmit the disease. • Resident #89 receives eye (3) The facility must require staff to wash their

(c) Linens

professional practice.

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

hands after each direct resident contact for which

hand washing is indicated by accepted

This REQUIREMENT is not met as evidenced by:

medication utilizing proper

infection control technique.

• Resident # 132 no longer resides at facility.

How will you identify other

will be taken?

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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F 441	review the facility infection control properties in facility of the glucose mach failed to cleanse in facility of the facility	tion, interview, and record failed to ensure staff followed rocedures related to sor and blood glucose machine ross contamination during a nange. This deficient practice sidents in a sample of 24; 2 of applemental sample 7 reviewed ection control measures. 88, #89, #96, #115, #132 and ed 7 staff members. (CNA # 5, LPN # 8, LPN #15, LPN #11, evation of the medication pass 1 p.m., with LPN #15 and the g (DoN) the following was an to do a blood sugar check on the LPN assembled the glucose ettes, put gloves on her hands, born. The LPN removed her in into the trash, and left the ealled to wash her hands after	F 44	 Residents who reside facility have the posterice be affected by the adeficient practice. Licensed Nurses were ducated on correct of glucometers, infectontrol practices we care and medication administration, by Development Coordinator/design March 4, 2011. Nursing staff were read on infection control passing ice water be Development Coordinator/design March 4, 2011. What measures will be performed place or what systemic clearly will make to ensure that deficient practice does not be upon hire and no learnually a skills vary will be completed on nurses in regards to control (glucometed disinfection, eye dispersion). 	tential to alleged re re- c cleansing ection ith wound in the Staff ee, by e-educated d while y the Staff ee by ut into nanges you the ot recur? ess than alidation on licensed o infection roops and		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
(155121	B. WING _		02/04	1/2011
	PROVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	- ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	the resident's stohands and went to LPN got an alcohold cart, picked up the the machine. The medication cart, resident to be chethe items needed DoN at that time. During an interviet the LPN indicated machine was not have wipes we are have any in myomedication cart for sure. The medication cart for sure. The medication cart for any properties on the medication cart. During an interviet the observation is placed a Kleenex machine and the medication cart. The LPN was stoto clean the machine and the medication cart.	administered the insulin into mach. The LPN washed her back to the medication cart. The ol pad out of the medication e glucose machine, and cleaned e LPN laid the machine on the The LPN identified the next ecked and began to assemble in the LPN was stopped by the extension and the latent of the observation, if using alcohol on the glucose appropriate. She indicated "We resupposed to use, but I don't eart." She checked her or the germicidal wipes to make ation cart did not contain a tub of The DoN then instructed the lechol was inappropriate and to tub of germicidal wipes from the did with the germicidal wipes from the glucose machine, and laid it in cart. The LPN failed to place a he glucose machine and the lew with the LPN at the time of the indicated she should have to paper towel between the	F 441	Staff Development Coordinator/designe Skills validations are completed 3 times a 1 month to ensure competency with infection on medication and treatments by Standard Development Coordinator/designe Nurse Managers will two ice water pass so validation on nursing week for one month competency with infection while passing water. DNS/designee is respensure compliance of facility procedure. How the corrective action monitored to ensure the depractice will not recur, i.e. quality assurance program put into place? An "Infection Controt tool will be utilized per week for one monitored to ensure the depractice will not recur, i.e. quality assurance program put into place?	week for fection on pass taff ee. complete kills g staff per to ensure fection ag ice consible to with (s) will be leficient c, what m will be of "CQI two times onth then nonths and	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
(155121	B. WIN	IG		02/0	1/2011
	PROVIDER OR SUPPLIER	FAYETTE	1	1	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	Kleenex. The LPN and entered the ne blood glucose. The hands after handlin machine, and befor room to perform carbon to perform the performance of the meter performance to the meter being the performance of the meter being the performance of the performanc	d laid the machine on the placed gloves on her hands, at residents room to check the LPN failed to sanitize her g the soiled blood glucose re entering the next resident's re. with the DoN immediately vation, she indicated the LPN riate infection control he blood sugar/insuling indicated the LPN should cidal cleaner to cleanse the cated the use of alcohol was indicated the LPN should between the machine and the er it was appropriately cleaned. PN should have sanitized her ing the room, after removing drawing up the insulin, and coiled glucose machine. Jure, dated 1/2010, titled prating and cleaning glucose the Executive Director on identified as current er. To prevent cross ag resident use Frequency meter is to be disinfected prior used, between each resident,	F	141	The CQI committee we review the data gather if threshold is not ach action plan may be defended. Noncompliance with for procedure may result employee education a disciplinary action, us including termination. Compliance date: March 4,	ered and nieved an eveloped. facility in and/or p to and n.	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155121	B. Wil	۱G _		02/0	4/2011
	ROVIDER OR SUPPLIER	AYETTE		1	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	on 1/24/11 at 4:22 Director of Nursing observed: The LPN began to on Resident #65. If glucose machine, thands, and entered wash her hands pri room after handling glucose machine. resident's glucose I gloves, threw them room. The LPN fairemoving her glove. The LPN proceeder glucose machine or get into the medical resident's insulin. If insulin for Resident cleanse her hands resident. The LPN and administered the stomach. The LPN back to the medical During an interview following the observations of the process. During an interview following the observations of the process.	vation of the medication pass p.m., with LPN #15 and the (DoN) the following was perform a blood sugar check the LPN assembled the he lancettes, put gloves on her the room. The LPN failed to or to entering the resident's a contaminated blood. The LPN checked the evel. The LPN removed her into the trash, and left the led to wash her hands after s. If to the med cart, laid the hand the med cart, and began to the the med cart, and began to the LPN drew up the required #65. The LPN failed to before preparing insulin for the entered the resident's room he insulin into the resident's washed her hands and went	F	441			
	the room, and after	taking off her gloves. She					

		I AND HUMAN SERVICES & MEDICAID SERVICES					1 APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- ' '	IULTIPL	E CONSTRUCTION	(X3) DATE S COMPL	SURVEY
()		155121	B. WI	1G		02/0	04/2011
	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP COD 33 UNION STREET	ÞΕ	
ROSEWA	ALK VILLAGE AT LAF	FAYETTE			FAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 72	F	441			•
	indicated she under infection control cor	rstood the inappropriate ncerns.					
		cation administration 5/11 at 8:40 a.m., with RN # 9 Nursing (DoN) the following					:
·	The RN had gloves administration of the eye drops to the residences and left the medication cart and resident's g-tube m	eye drops to Resident #89. on his hands during the e eye drops. After instilling the sident, the RN removed his room. The RN returned to the d began to prepare the edications. The DoN stopped in to go back into the room and					
	following the observ	with the RN immediately vation, he indicated he should ands after he removed his					
	observation, she in	with the DoN following the adicated the RN should have after removing his gloves.					:
•		vation on 1/25/11 at 10:40 I and the Director of Nursing was observed:		:			
	change Resident # entered the residen the bedside table for	od the supplies needed to 88's dressing on his heel. She ot's room, placed a towel over or a barrier. The LPN placed towel. The LPN removed a		:			

pair of scissors from her pocket and laid them on the towel with the other supplies. The LPN used the scissors to remove the old gauze dressing, PRINTED: 02/14/2011

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
<i>(</i>		155121	B. Wi	NG _		02/0	4/2011	
	PROVIDER OR SUPPLIER	AYETTE	•	1	REET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
	the dressing was recleansed, the LPN the clean gauze after foot. At no time dur LPN cleanse her so. During an interview observation, the LPI clean and had not be should have clean and during the them and during the following the observation of the work of the inside of the work of the inside of the outs LPN # 8 then took the outside of the packathe resident's open with the technique used the wound. She further	the dressing change. After moved and the wound was used the same scissors to cut er re-wrapping the resident's ing the observation did the issors. immediately following the N indicated her scissors were een used yet. She indicated aned them before she used aned them before she used a dressing change. with the DoN immediately ation, she indicated the LPN sure the scissors were not them during the dressing on of a dressing change, on , for Resident # 96, with LPN of Nursing present, the yed: The resident's wound. LPN # 8 with normal saline and the wound, and then patted and with the same piece of a piece of silver alginate and ide of an empty package. The silver alginate from the ge and placed it directly on	F	441				

PRINTED: 02/14/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 02/04/2011 155121 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1903 UNION STREET ROSEWALK VILLAGE AT LAFAYETTE LAFAYETTE, IN 47904 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID. SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 441 Continued From page 74 F 441 the alginate on the outside of the opened package. 6. During observation of a dressing change, on 1/26/11 at 9:50 A.M., for Resident # 132, with LPN #6 and the Director of Nursing, the following was observed: The resident had an open area at the site of the right great toe amputation. At that time, treatment was applied to the resident's toe and the resident's wound was dressed according to the physician's orders. LPN # 6 wore gloves throughout the dressing change, but did not apply any additional personal protective equipment. During observation on 1/27/11 at 10:15 A.M., there was no isolation sign or isolation cart present in the resident's room. The clinical record for Resident # 132 was reviewed on 1/26/11 at 3:55 P.M. Diagnoses for the resident included, but were not limited to, osteomyelitis of the right great toe with amputation. A nursing note, dated 1/14/11 at 3:30 P.M., indicated, "Res (resident) returned from appt.

MRSA in the right foot.

(appointment) N.O. (new order) for contact isolation d/t (due to) MRSA (methicillin resistant staphylococcus aureus) to R (right) foot...."

A physician's order, dated 1/14/11, indicated the resident was to be in contact isolation due to

During an interview with the Director of Nursing on 1/27/11 at 10:50 A.M., she indicated if a wound was draining, then staff would be expected

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
r <u>;</u> '	:	155121	B. WII	۷G		02/0	04/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LAF	AYETTE		19	EET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 75	F	141			
	stop sign on the doo	e indicated there should be a or to alert visitors.		:			
•	the Corporate Nurse 12:30 P.M., titled "C "Contact Precauti and control nosocor with any of the follow	icy, dated 1/09, provided by e Consultant on 2/4/11 at contact Precautions" indicated, ons are indicated to prevent mial transmission of infection wing: Staphylococcus Methicillin/oxacillin if present					
	in a site that has co contained, i.e., drain Post a sign at the re	pious secretions not ning woundPrecaution Sign: esident's door to advise the ith the Charge Nurse before					
	a.m., CNA (Certified observed passing in 2nd floor East hall. different resident rooms)	vation on 01/25/2011 at 9:45 I Nursing Assistant) # 5 was be water to residents on the The CNA entered three oms without sanitizing or between passing ice water to					
	each resident. The surfaces including the individual water pitolibathroom faucets are resident's rooms. The 148 with a drink by head of the surface of the s	CNA touched multiple ne residents' bedside tables, hers, bathroom doors,					
	CNA # 5 indicated s her hands. She indic	on 01/25/2011 at 9:50 a.m., he did not sanitize or wash cated she should have between resident rooms.		:			
	# 3 and the ADoN (A indicated the CNA si	on 01/25/2010 at 10 a.m., RN Assistant Director of Nursing) hould have washed her sing water to each resident.	·				:

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155121	B. Wii	NG _		02/0	4/2011
	ROVIDER OR SUPPLIER	AYETTE		1	REET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 76	F	441			
	the DoN (Director o expect hand washin	on 01/25/2010 at 10:20 a.m., f Nursing) indicated she would g to occur before the CNA with her drinking glass.					
	"Passing Fresh Ice" DoN. The policy inc the resident a drink present. Repeat pro	ed 02/2010 and titled, Water" was provided by the dicated, "Wash hands Offer of fresh water if resident is ocedure until all resident's with fresh ice water. Wash					
	8. The clinical recorreviewed on 01/27/2	rd for Resident # 148 was 2011 at 10:45 a.m.					
	weakness, renal (kid obstructive pulmona amenia (decrease ir	, but were not limited to, dney) failure, COPD (chronic ary disease), pacemaker, n the number of red blood flammation of the skin), and on).					
	a.m., LPN # 2 provid 148's bilateral buttoo Director of Nursing) the wound care. LP ampules that had be resident's wound into	on on 01/25/2011 at 11:05 ded wound care to Resident # cks. The ADoN (Assistant observed the LPN perform N # 2 placed normal saline een used to cleanse the o a plastic bag containing ne LPN touched the inside of					
:		her gloved hand, then e without washing her hands oves.					
	the ADoN indicated	on 01/25/2011 at 11:30 a.m., the LPN should not have f the plastic bag with her					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155121	B. WI	NG_		02/0	04/2011
	PROVIDER OR SUPPLIER ALK VILLAGE AT LA		1	1	REET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET LAFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441 F 502 SS=E	gloved hands and without washing he gloves. 3.1-18(I) 483.75(j)(1) PROV SVC-QUALITY/TII The facility must p services to meet th facility is responsit of the services. This REQUIREME by: Based on record refailed to ensure lat the physician for 3 completed laborate (Residents # 26, # Findings include: 1. Resident # 26's 1/28/11 at 10:00 a. #26 included, but v (stroke), atrial fibril hypertension, CAD a history of conges Medication Administrational decided the medicanticoagulant medical A physician's order	then resumed wound care er hands and applying new IDE/OBTAIN LABORATORY MELY rovide or obtain laboratory ne needs of its residents. The ole for the quality and timeliness INT is not met as evidenced eview and interview, the facility os were obtained as ordered by of 24 residents reviewed for ory services in a sample of 24. 88, and #96). record was reviewed on m. Diagnoses for Resident vere not limited to, CVA lation, cardiac arrhythmias, (coronary artery disease), and tive heart failure. stration Records, dated cated the physician orders ation warfarin (Coumadin), an cation.			F502 Provide/Ohtain Labo	ity to services lents in a will be idents d by the I/INR th n and being umadin drawn, ed. in was tained e. r tial to be	
	facility was to draw	a PT/INR laboratory test on lation was lacking to indicate		ļ	anected by the same deficit	ant	

PRINTED: 02/14/2011 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION IG	(X3) DATE SI COMPLE	
		155121	B. WII	4G _		02/0	4/2011
	PROVIDER OR SUPPLIER	AYETTE	1	1	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET		
				L	AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 502	Continued From pa	ge 78	F	502	practice and what correctiv	e action	
		awn as ordered by the			will be taken?		
	(DoN) on 1/28/11 at lab had not been do physician. 2. Resident #88's re	with the Director of Nursing t 3:10 p.m., she indicated the one as ordered by the ecord was reviewed on 1/25/10			 Residents who require testing have the poten be affected by the alle deficient practice. Licensed staff and nurs managers have been remarked. 	tial to ged se	
	included, but were r	oses for Resident #88 not limited to, anemia, trial fibrillation, coronary artery trition.			educated on lab tracki the DNS/designee by 4, 2011.	ng by	
	indicated "CBC (c 1/8/11CMP (comp on 1/8/11" Docur	dated 1/8/11 at 9 p.m., omplete blood count) on orehensive metabolic panel) mentation was lacking to been drawn as ordered by			What measures will be put place or what systemic chan will make to ensure that the deficient practice does not r	iges you	
	10:30 a.m., she indi documentation relat as ordered by the pl she spoke with som CBC and CMP had	·			 Lab orders are reviewe morning clinical meet (Monday – Friday). Lab binders will be brothe morning clinical numbers (Monday – Friday) to 	ing ought to neeting	
	11:40 a.m., she indi documentation relat done as ordered by				 for the completion of Notify lab through requ When lab results return physician for clinical 	labs. uisition. i notify	
:	reviewed on 1/25/11	d for Resident # 96 was at 10:15 A.M. Diagnoses for d, but were not limited to, is.			 and notify responsible of new orders. Physician orders will be reviewed in the morning of the control of the	party e	
	The physician's orde	er summary for 1/11 indicated			meeting (Monday thru	_	

meeting (Monday thru Friday)

NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE CAMPIE STREET ADDRESS, CITY, STATE, ZIP CODE 1993 UNION STREET LAFAYETTE, IN 47994			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NÜMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ROSEWALK VILLAGE AT LAFAYETTE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 502 Continued From page 79 the resident had a current physician's order for Coumadin (a medication to increase bleeding time) 5 milligrams by mouth on Tuesday, Thursday, and Saturday and Coumadin 7.5 milligrams by mouth on Monday, Wednesday, Friday, and Sunday. A physician's order, dated 11/24/10, indicated, "Hold cournadin today 11/24/10 resume current dose on 11/25/10 recheck PT/INR (a laboratory test to measure bleeding times) in 2 weeks 12/8/10" There was no laboratory result in the clinical record to indicate the PT/INR was drawn on 12/8/10 as ordered by the physician. A laboratory requisition form, dated 12/6/10, had a hand written note which indicated, "cancel PT/INR for 12/8/10" There was no physician's order in the clinical record to cancel the 12/8/10 PT/INR. During an interview with the Director of Nursing on 2/4/11 at 10:30 A.M., she indicated there was not a physician's order to discontinue the lab on	$\int_{0}^{\infty} \int_{0}^{\infty} dt$		155121	B WING			4/2011		
F 502 Continued From page 79 the resident had a current physician's order for Cournadin (a medication to increase bleeding time) 5 milligrams by mouth on Tuesday, Thursday, and Saturday and Cournadin 7.5 milligrams by mouth on Monday, Wednesday, Friday, and Sunday. A physician's order, dated 11/24/10, indicated, "Hold cournadin today 11/24/10 resume current dose on 11/25/10 recheck PT/INR (a laboratory test to measure bleeding times) in 2 weeks 12/8/10" There was no laboratory result in the clinical record to indicate the PT/INR was drawn on 12/8/10 as ordered by the physician. A laboratory requisition form, dated 12/6/10, had a hand written note which indicated, "cancel PT/INR for 12/8/10" There was no physician's order in the clinical record to cancel the 12/8/10 PT/INR. During an interview with the Director of Nursing on 2/4/11 at 10.30 A.M., she indicated there was not a physician's order to discontinue the lab on					STREET ADDRESS, CITY, STATE, ZIP CODE 1903 UNION STREET				
the resident had a current physician's order for Coumadin (a medication to increase bleeding time) 5 milligrams by mouth on Tuesday, Thursday, and Saturday and Coumadin 7.5 milligrams by mouth on Monday, Wednesday, Friday, and Sunday. A physician's order, dated 11/24/10, indicated, "Hold coumadin today 11/24/10 resume current dose on 11/25/10 recheck PT/INR (a laboratory test to measure bleeding times) in 2 weeks 12/8/10" There was no laboratory result in the clinical record to indicate the PT/INR was drawn on 12/8/10 as ordered by the physician. A laboratory requisition form, dated 12/6/10, had a hand written note which indicated, "cancel PT/INR for 12/8/10" There was no physician's order in the clinical record to cancel the 12/8/10 PT/INR. During an interview with the Director of Nursing on 2/4/11 at 10:30 A.M., she indicated there was not a physician's order to discontinue the lab on	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE	
time. She indicated it was an error. 4. A policy and procedure dated July 08, titled "Guidelines for lab tracking" provided by the DoN on 1/26/11 at 11:30 a.m., identified as current indicated "set up a lab tracking binder with a list fordaily labs, weekly labs, monthly labsreview MD orders and place in tracking binder at time order reviewed. When ordering lab-fax order to alb, then place it in separate binder at nurses' station. When lab comes to draw lab-nurse to • A "Lab Tracking" CQI tool will be utilized 2 times a week for 1 month then weekly for 2 months and then quarterly. • The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.	F 502	the resident had a commadin (a medicitime) 5 milligrams by Thursday, and Saturnilligrams by mouth Friday, and Sunday A physician's order, "Hold coumadin took dose on 11/25/10 retest to measure blee 12/8/10" There was no laborated to indicate the 12/8/10 as ordered A laboratory requisit a hand written note PT/INR for 12/8/10. There was no physicandered to cancel the During an interview on 2/4/11 at 10:30 Anot a physician's ord 12/8/10 and it should time. She indicated 4. A policy and procedure in She indicated to 1/26/11 at 11:30 indicated " set up a for doily labs, week MD orders and placoorder reviewed. Whealb, then place it in set in the she in th	current physician's order for cation to increase bleeding by mouth on Tuesday, orday and Coumadin 7.5 in on Monday, Wednesday, orday and Coumadin 7.5 in on Monday, Wednesday, orday 11/24/10 resume current echeck PT/INR (a laboratory eding times) in 2 weeks atory result in the clinical se PT/INR was drawn on by the physician. Ition form, dated 12/6/10, had which indicated, "cancel or "cancel o	F	502	ensure lab orders are and care plans are up needed. • The lab order is placed lab tracking form and charge nurse/unit man responsible for follow • The lab tracking form reviewed in the morn meeting to ensure follow with lab test is complianted for trass needed. • DNS/designee is responsible to ensure compliance with facility procedure. How the corrective action(s monitored to ensure the despractice will not recur, i.e., quality assurance program put into place? • A "Lab Tracking" CQ will be utilized 2 times for 1 month then weed months and then quared to the data gather if threshold is not ach	tracked dated as d on the lithe mager is v-up. will be ing low up eted and eatment onsible to ith b) will be ficient what will be I tool es a week kly for 2 terly. ill red and ieved an ieved an ieved an ieved an ieved an ieved as		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
1 1		155121	B. WIN	G		02/0	4/2011
	ROVIDER OR SUPPLIER	FAYETTE		19	EET ADDRESS, CITY, STATE, ZIP CODE 003 UNION STREET AFAYETTE, IN 47904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	i	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 502	copy of form with n binderMonthly- re	rrival and upon departure-put urses signature in the lab draw wiew lab tracking binder at the of the rewrites to ensure lab	F	502	 Noncompliance with procedure may resul employee re-educati disciplinary action, including terminatio 	t in on and/or up to and	
F 505 SS=D	OF LAB RESULTS	omptly notify the attending	F 5	605	F505 Promptly Notify Phy Lab Results It is the practice of this facil.	vsician of	
(by: Based on record re failed to ensure pro an abnormal lab for abnormal labs in a (Resident # 19)	NT is not met as evidenced view and interview, the facility mpt physician notification of 1 of 24 residents reviewed for sample of 24 residents			promptly notify the attendir physician of the findings. What corrective action(s) accomplished for those refound to have been affected deficient practice?	ng will be sidents	
	Diagnoses for Resi not limited to, CHF diabetes type 2, and red blood cells), alto cardiomyopathy (de	dent # 19 included, but were (congestive heart failure), emia (decreased number of			• Resident #19 receive medications per PEG per physician orders. How will you identify other residents having the potent affected by the same defic practice and what correct will be taken?	G tube as c. er ntial to be ient	
	abnormal lab value Hemoglobin (a prot	dated 01/12/2011, indicated s including, but not limited to, ein in red blood cells that at 9.6 (normal was 14-18),			 Residents who require testing have the potential 		

- be affected by the alleged deficient practice.
- Licensed staff and nurse managers have been reeducated on lab tracking by the DNS/designee by March 4, 2011.

What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?

- Lab orders will be reviewed in morning meeting (Monday thru Friday) to ensure that labs are being ordered and results reported timely to the physician with treatment orders obtained as needed.
- Physician orders will be reviewed in the morning meeting (Monday thru Friday) by Nurse Management to ensure lab orders are tracked and care plans are updated as needed.
- The lab order is placed on the lab tracking form and the charge nurse/unit manager is responsible for follow-up.
- The lab tracking form will be reviewed in the morning

- meeting to ensure follow up with lab test is completed and orders obtained for treatment as needed.
- DNS/designee is responsible to ensure compliance with facility procedure.

How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?

- A "Lab Tracking" CQI tool will be utilized 2 times a week for 1 month then weekly for 2 months and then quarterly.
- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011

If continuation sheet 81B of 84

T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	155121	B. WING_		02/04/2011	
		1	1903 UNION STREET		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE COMPL	LETION
Hematocrit (meas volume of whole be blood cells) low at A physician's order Ferrous Sulf (Sulf (Sulf (Elixir) 7.4 ml (325) (three times daily)) During an intervie the DoN indicated physician on 01/12 was reviewed by the order was writindicated the facilitimely follow up with the order was writingly follow up with the sulf (1) (2) 483.75(l)(1) RES RECORDS-COMILE The facility must resident in accord standards and pragacurately documents and pragacurately documents or sulf (1) (2) (3) (4) (4) (4) (5) (6) (6) (6) (7) (7) (7) (7) (7) (7) (7) (7) (7) (7	sures the percentage of the blood that is made up of red 28.6 (normal was 40-54). er, dated 01/21/2011, indicated, lfate) 220/5 ml (milliliter) elx mg (milligram) per peg tube tid mg (milli	F 514	F514 Clinical Records It is the practice of this provion maintain clinical records on eresident in accordance with a professional standards and professional standards are complete; accurately documented; readily accessibly systematically organized. What corrective action(s) was accomplished for those resident to have been affected deficient practice? • Resident #88 code states	ach ccepted actice le; and ill be dents by the	
by:	. : :		reviewed with clinical	record	
	SUMMARY S' (EACH DEFICIENT REGULATORY OR REGULATORY OR REGULATORY OR SUPPLIER ALK VILLAGE AT LASUMMARY S' (EACH DEFICIENT REGULATORY OR RECORDS SUPPLIES THE Facility of Indicated the facility was reviewed by the order was writindicated the facility must reviewed by the order was writindicated the facility must resident in accord standards and president in acco	The CORRECTION IDENTIFICATION NUMBER: 155121 PROVIDER OR SUPPLIER ALK VILLAGE AT LAFAYETTE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 81 Hematocrit (measures the percentage of the volume of whole blood that is made up of red blood cells) low at 28.6 (normal was 40-54). A physician's order, dated 01/21/2011, indicated, "Ferrous Sulf (Sulfate) 220/5 ml (milliliter) elx (elixir) 7.4 ml (325 mg (milligram) per peg tube tid (three times daily)." During an interview on 01/26/2011 at 2:30 p.m., the DoN indicated the lab was faxed to the physician on 01/12/2011 but was unsure if the fax was reviewed by the physician prior to the date the order was written for Ferrous Sulfate. She indicated the facility should have pursued a more timely follow up with the physician. 3.1-49(f)(2) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced	TOTAL STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 81 Hematocrit (measures the percentage of the volume of whole blood that is made up of red blood cells) low at 28.6 (normal was 40-54). A physician's order, dated 01/21/2011, indicated, "Ferrous Sulf (Sulfate) 220/5 ml (milliliter) elx (elixir) 7.4 ml (325 mg (milligram) per peg tube tid (three times daily)." During an interview on 01/26/2011 at 2:30 p.m., the DoN indicated the lab was faxed to the physician on 01/12/2011 but was unsure if the fax was reviewed by the physician prior to the date the order was written for Ferrous Sulfate. She indicated the facility should have pursued a more timely follow up with the physician. 3.1-49(f)(2) 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	This REQUIREMENT is not met as evidenced by the State; and progress notes. A BUILDING B. WING	This REQUIREMENT is not met as evidenced by: **RESIDENCE OF CORRECTION** **IDENTIFICATION NUMBER:** 155121 **A BUILDING** **BUILDING** **BUILDING** **BUILDING** **BUILDING** **BUILDING** **BUILDING** **BUILDING** **BUILDING** **BUILDING** **STREET ADDRESS, CITY, STATE, ZIP CODE** **BO3 JINION STREET* **LEFAMPETE, IN 47904 **STREET* **LEFAMPETE, IN 47904 **PROVIDER'S ITAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE* **CORDINATION OF ILSO LIBERTIFYING INFORMATION*) **PROVIDER'S ITAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE* **CORDINATION OF ILSO LIBERTIFYING INFORMATION*) **PROVIDER'S ITAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE* **CORDINATION OF ILSO LIBERTIFY ADDRESS ITAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE* **CORDINATION OF ILSO LIBERTIFY ADDRESS ITAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE* **CORDINATION OF ILSO LIBERTIFY AND APPROPRIATE* **CORDINATION OF ILSO LIBERTIFY AND APPROPRIATE* **CORDINATION OF ILSO LIBERTIFY AND APPROPRIATE* **DID PROVIDER'S LAND OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE* **CORDINATION OF ILSO LIBERTIFY AND APPROPRIATE* **ID DO IN INDUSTREET* **LEFAMPET* **CORDING** **COR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			(X3) DATE SU COMPLE				
	155121	B. Wil	√G _		02/04/		
NAME OF PROVIDER OR SUPPLIER ROSEWALK VILLAGE AT LAFAYETTE			1	REET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904			
PREFIX (EACH DEFICIEN				ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
related to code st effected 1 of 24 and accurate clin 24. (Residents # Findings Include: The clinical record on 1/25/11 at 3:25 resident included hypertension, confibrillation, anemia Resident #88 was 12/6/10. A "patient transferdated 12/6/10, incomo code blue" A "physician's ordidated 12/6/10, incomo code blue" The physician's ordidated 12/6/10, incomo code blue" The physician's ordidated the resident for the physician's ordinated the	linical records were accurate atus. This deficient practice residents reviewed for complete cal records in a total sample of (38) If for Resident #88 was reviewed to p.m. Diagnoses for the but were not limited to, conary artery disease, atrial a, malnutrition, and depression. It is admitted to the facility on the facility on the facility on the hospital, licated, "Resuscitation status: If orm from the hospital, licated "code status: no code of the summary for 12/10, then was a "no code blue" If der summary for 1/11, did not not second to the status: If orgress note, dated 12/16/10, resident) is a full code" If 12/21/2010, indicated cosen [sic] to have life resgoalresident will received that yesselves to the summary resuscitation] and	F	514	updated to reflect curstatus. How will you identify other residents having the potent affected by the same deficie practice and what corrective will be taken? • All residents who reside facility have the potent be affected by the alledeficient practice. • Resident's clinical recover reviewed to ensure appropriate document code status. What measures will be put place or what systemic charwill make to ensure that the deficient practice does not a licensed Nurses were re-educated on the policy on advances directives, by March 4, 2011. • Upon admission and with significant changes advance directives are	ial to be ent ve action de in the ntial to eged ords ure tation of into nges you e		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
(* :		155121	B. WIN	IG		02/04	I/2011	
	ROVIDER OR SUPPLIER ALK VILLAGE AT LAF	FAYETTE		19	EET ADDRESS, CITY, STATE, ZIP CODE 903 UNION STREET AFAYETTE, IN 47904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 514	10:30 a.m., she ind Resident # 88 was documentation in the indicated the reside code. During an interview on 1/26/11 at 10:35 not sure why there	ge 83 with LPN #11 on 1/26/11 at icated the code status for not clear based on the ne clinical record. She ent was supposed to be a full with the Director of Nursing a.m., she indicated she was was conflicting documentation d. She indicated the resident	F	514	reviewed with reside and responsible party DNR forms will be side dated and will be platesidents charts. The CODE order will be on residents' medicate record. CODE STATUS will reviewed with reside responsible party during the quarterly care planed and for during signification. If resident or responsible decides to change the status the physician we contacted and a new will be obtained. DNS/designee is responsive ensure compliance we facility procedure. How the corrective action (monitored to ensure the depractice will not recur i.e., quality assurance program put into place?	gned and ced in the e NO indicated tion be nt and or ing the onference ficant ble party e code will be order onsible to with s) will be efficient what		
			:		An "Advanced Direct CQI tool will utilized times four and then n	l weekly		

- times 2 and then semi annually thereafter.
- The CQI committee will review the data gathered and if threshold is not achieved an action plan may be developed.
- Noncompliance with facility procedure may result in employee re-education and/or disciplinary action, up to and including termination.

Compliance date: March 4, 2011